Missouri

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/01/2021 4.43.38 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State SAPT DUNS Number

Number 7808714300

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Missouri Department of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address PO Box 687

City Jefferson City

Zip Code 65102-0687

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Nora

Last Name Bock

Agency Name Missouri Department of Mental Health

Mailing Address PO Box 687

City Jefferson City

Zip Code 65102-0687

Telephone 573-751-9499

Fax 573-751-7814

Email Address nora.bock@dmh.mo.gov

State CMHS DUNS Number

Number 780871430

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Missouri Department of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address P.O. Box 687

City Jefferson City

Zip Code 65102-0687

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Nora

Last Name Bock

Agency Name Missouri Department of Mental Health

Mailing Address	P.O. Box 687
City	Jefferson City
Zip Code	65101-0687
Telephone	573-751-9499
Fax	573-751-7814
Email Address	nora.bock@dmh.mo.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	9/1/2021 3:08:45 PM
Revision Date	9/1/2021 3:09:08 PM

VI. Contact Person Responsible for Application Submission

First Name	Renee
Last Name	Rothermich
Telephone	573-522-8077
Fax	573-751-7814
Email Address	Renee.Rothermich@dmh.mo.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
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   b. Collecting a certification statement similar to paragraph (a)
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Missouri

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: Mark Stringer

Title: Director

Date Signed: 08/12/2021

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE CAPITOL
201 W. CAPITOL AVENUE, ROOM 216
JEFFERSON CITY, MISSOURI 65101

(573) 751-3222
WWW.GOVERNOR.MO.GOV

Michael L. Parson

GOVERNOR
STATE OF MISSOURI

July 31, 2018

Odessa F. Crocker
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse Mental Health Services Administration
5600 Fishers Lane, 17th Floor
Rockville, Maryland 20850

Dear Ms. Crocker:

Please be advised that I have delegated signatory authority to the current Director of the Department of Mental Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the following Substance Abuse and Mental Health Services Administration (SAMHSA) grants and reports until such time as I may modify or rescind this designation:

1) Substance Abuse Prevention and Treatment Block Grant (SABG),
2) Community Mental Health Services Block Grant (MHBG),
3) Projects for Assistance in Transition from Homelessness (PATH) Grant, and the
4) Annual Synar Report.

Sincerely,

Michael L. Parson,
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
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2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee[1]: Mark Stringer

Title: Director

Date Signed: 08/12/2021

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

STATE CAPITOL
201 W. CAPITOL AVENUE, ROOM 216
JEFFERSON CITY, MISSOURI 65101

(573) 751-3222
WWW.GOVERNOR.MO.GOV

Michael L. Parson

GOVERNOR
STATE OF MISSOURI

July 31, 2018

Odessa F. Crocker
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse Mental Health Services Administration
5600 Fishers Lane, 17th Floor
Rockville, Maryland 20850

Dear Ms. Crocker:

Please be advised that I have delegated signatory authority to the current Director of the Department of Mental Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the following Substance Abuse and Mental Health Services Administration (SAMHSA) grants and reports until such time as I may modify or rescind this designation:

1) Substance Abuse Prevention and Treatment Block Grant (SABG),
2) Community Mental Health Services Block Grant (MHBG),
3) Projects for Assistance in Transition from Homelessness (PATH) Grant, and the
4) Annual Synar Report.

Sincerely,

Michael L. Parson,
Governor

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name
Mark Stringer

Title
Director

Organization
Missouri Department of Mental Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Missouri's Behavioral Health System of Care

Overview and structure

With a population of over six million people, Missouri provides a rich diversity of rural and urban landscapes. The state has 114 counties and the independent city of St. Louis. Approximately 82.9 percent of the population is Caucasian, 11.8 percent are African-American, 2.2 percent are Asian, and 3.1 percent are of multi-race or other race. About 4.4 percent of the state's population is Hispanic (U.S. Census Bureau, 2021). Large populations of African-Americans are present in the state's metropolitan areas of St. Louis and Kansas City, as well as the rural southeast "Bootheel" area. The state's largest Hispanic population is in the Kansas City area. Although the state does not have any federally recognized tribes, small populations of Native Americans make their home near the Oklahoma border. Approximately 494,346 Missouri residents are veterans (Missouri Department of Public Safety, 2021).

At $328.4 billion in 2019, Missouri's Gross State Product (GSP) ranked 35th among states. As of June 2021, the state's unemployment rate stood at 4.3 percent, which is slightly lower than that for the country as a whole (5.4%) (Missouri Department of Labor and Industrial Relations, 2021). Missouri has 16 counties plus the independent city of St. Louis that have poverty rates of at least 20 percent (USDA Economic Research Service, 2021). Most of these counties are located in the southern portion of the state.

The Missouri Department of Mental Health (DMH) is one of sixteen state agencies under the executive branch of state government. DMH collaborates on initiatives with other state agencies including the Departments of Corrections (DOC), Transportation (DOT), Elementary and Secondary Education (DESE), Health and Senior Services (DHSS), Public Safety (DPS), and Social Services (DSS). DSS is the Medicaid authority for the state. DMH's close, collaborative relationships with DOC and DSS, in particular, are strengths to the state's behavioral health system. The principal missions for DMH as established in state law are to: 1) prevent mental disorders, developmental disabilities, substance use, and compulsive gambling; 2) treat, habilitate, and rehabilitate Missourians who have these conditions; and 3) improve the public understanding and attitudes about mental disorders, developmental disabilities, substance use, and compulsive gambling. DMH has representation on various interagency groups including:

- Access Crisis Intervention (ACI), Community Behavioral Health Liaisons (CBHL), Emergency Room Enhancement (ERE) Council Meetings;
- Access and Functional Needs Committee;
- ACI/ERE/CBHL Joint Quarterly Meetings;
- Behavioral Pharmacy Management (BPM);
- Certified Community Behavioral Health Organizations Prospective Payment System (CCBHO PPS) Leadership Group;
- Children and Youth in Disasters Committee;
- Children's Division Healthcare Coordination Committee, Behavioral Health Workgroup;
- Comprehensive System Management Team (for state agencies providing services to children);
- Continuity of Operations Planning;
- Council for Adolescent and School Health;

- Cross Over Youth State Policy Advisory Committee;
- Department of Corrections/Department of Mental Health (DOC/DMH) Oversight Committee;
- Division of Social Services (DSS) Critical Incident Review Panel;
- Early Childhood Comprehensive System Steering Committee;
- Eating Disorders Council;
- Emergency Preparedness Committee;
- Emergency Room Workgroup;
- Families First Implementation Statewide Advisory Council;
- Governor's Challenge to Prevent Suicide amongst Service Members, Veterans, and Their Families;
- Governor's Committee to End Homelessness;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Homeland Security Advisory Committee;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Individualized Placement and Support Collaborative Meetings;
- Improving Community Treatment Success (ICTS) Oversight Team;
- JRI Executive Oversite Committee;
- JRI Behavioral Health Work Group;
- JRI Crisis Response Work Group;
- JRI Evidence-based Practices in DOC Work Group;
- JRI Victim's Work Group;
- JRI Data Sharing Work Group;
- Kids Win Missouri Child Care Advisory Group;
- Local Continuum of Care Meetings;
- Maternal/Fetal Health Workgroup;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;
- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Missouri 988 Task Force;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Missouri Alliance for Drug Endangered Children;
- Missouri Alliance to Curb Problem Gambling;
- Missouri Council for Behavioral Healthcare Liaison group;
- Missouri Behavioral Health Epidemiology Workgroup;
- Missouri Coordinated School Health Coalition;
- Missouri Head Start Advisory Council;
- Missouri Treatment Courts Coordinating Commission;
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Injury and Violence Prevention Advisory Council;
- Missouri Lifespan Respite Coalition;
- Missouri Prevention Partners Coalition;
- Missouri School-Based Health Alliance State Advisory Council;
- Missouri Suicide Prevention Network (MSPN);
- Missouri Children's Justice Act Task Force;

- Missouri Viral Hepatitis Stakeholder Workgroup;
- Mo HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform;
- Mo HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- MO HealthNet (Medicaid) Stakeholder Advisory Committee Behavioral Health Carve In Project;
- National Treatment Coordinators, subgroup of National Association of State Alcohol and Drug Abuse Directors (NASADAD);
- Office of Childhood;
- Primary Care/DMH Integrated Care Workgroup;
- Sexual Violence Prevention Planning Stakeholders Committee;
- Show Me Response (disaster & emergency coordination);
- Stakeholders Advisory Group;
- State Mass Care Committee;
- State of Missouri Brain Injury Advisory Council;
- State Tobacco Community of Practice;
- Substance Use Disorder Workgroup, Missouri Behavioral Health Council;

DMH is comprised of the Divisions of Behavioral Health (DBH), Developmental Disabilities (DD), and Administration. The Department's supportive offices include the Offices of Deaf Services, Constituent Services, and Comprehensive Child Mental Health. In November 2012, Missouri voters approved a measure that prohibits the Governor or any state agency from establishing or operating a state-based health insurance exchange without legislative or voter approval. On August 4, 2020, Missouri voters approved an initiated constitutional amendment to expand Medicaid. However, the Missouri legislature did not appropriate funds to support the expansion. Subsequently, a petition was filed in the Circuit Court of Cole County, Missouri, challenging the legislature's failure to fund Medicaid expansion. The Circuit Court found that the amendment was unconstitutional. The decision was appealed to the Missouri Supreme Court, which unanimously found on July 22, 2021 that the amendment was constitutional and remanded the case back to the Cole County Circuit Court to address implementation. On August 10, 2021, the Circuit Court found that Missouri is required to open Medicaid eligibility to the expansion population as set out in the amendment. On August 11, 2021, the Governor's Office announced there would be a 60-day delay in opening the enrollment to allow for the necessary computer systems and staffing to be put in place. The expansion opens up Missouri's Medicaid program to approximately 275,000 additional individuals making less than $18,000 per year.

The director of the Department of Mental Health (DMH) is appointed by the Missouri Mental Health Commission and confirmed by the state Senate. Comprised of seven members appointed by the Governor, the Mental Health Commission serves as the principal policy advisory body to the department director. The Commission, by law, must include an advocate of community mental health services; a physician who is an expert in the treatment of mental illness; a physician with an awareness of developmental disabilities; a member with business expertise; an advocate of substance use treatment; and a citizen who represents the interests of consumers of developmental disabilities services

The Department Director appoints the division directors. The director of the Division of Behavioral Health (DBH) is responsible for leading and managing the DBH division; directing policy and strategic plans for DBH; coordinating with other state officials; and representing DBH in discussions, negotiations, and partnerships with other state and federal organizations. DBH is organized into the following functional units:

- Community Programs,
- Psychiatric Facility Operations,
- Children's Services,
- Recovery Services,
- Prevention and Mental Health Promotion,
- Administration (fiscal),
- Data and Research, and
- Regional Operations.

Community Programs

Included under Community Programs are all mental health and substance use community-based treatment programs, the Substance Awareness Traffic Offender Program (SATOP), Healthcare Homes, certification, and fidelity review. In addition to leading and managing these programs, the Deputy Director for Community Treatment is also responsible for working with key stakeholders, to include other state agencies, to improve community-based services. The Division of Behavioral Health (DBH) contracts with 62 community-based agencies for the provision of substance use treatment and/or psychiatric rehabilitation services: 34 for substance use treatment only, 13 for psychiatric rehabilitation services only, and 15 for both. The certification standards of care contain core rules for Psychiatric and Substance Use Disorder Treatment Programs, updated in 2019, and will continue to be reviewed/updated every 5 years, which apply to both mental health and substance use programs. Separate certification standards of care for mental health and substance use disorder treatment programs include the specific service delivery requirements for each program, including staff qualifications, required services, and environmental and safety practices. DBH staff conduct annual billing reviews of contracted community organizations. DBH certifies 111 organizations for substance use treatment, and 76 organizations for mental health treatment.

The Department of Mental Health's (DMH) value statement specifies, "Missourians who participate in mental health services are welcomed and equally included in education, work, housing, and social opportunities in their communities." (DMH, 2021). Core standards require that services be delivered in a manner that is responsive "to each individual's developmental needs, cultural background, gender identity, gender expression, language and communication skills, sexual orientation, and other factors as indicated" (9 CSR 10-7.010). DMH requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are to be available to individuals in treatment whose preferred language is a language other than spoken English. DMH's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing, or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either

by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. DMH's information system collects data on client characteristics including race, ethnicity, preferred language, hearing status, and gender identity (ISO 5218). Such data is aggregated by geographical areas for analysis. DMH is a provider of cultural competency trainings for the state's behavioral health and prevention workforce. Cultural competency training is included in DMH's annual Spring Training Institute that is attended by approximately 800 behavioral health and human service professionals.

All individuals in need of behavioral health services from facilities operated by Division of Behavioral Health (DBH) contracted service providers receive an initial assessment. For individuals needing substance use treatment, an individual receives a structured interview completed by a Qualified Addiction Professional (QAP), with a diagnosis rendered by a licensed diagnostician. For individuals seeking services from the Substance Awareness Traffic Offender Program (SATOP), the self-administered Driver Risk Inventory II (DRI-II), in conjunction with an individualized interview with a SATOP Qualified Professional (SQP), determines the level of program placement. For individuals needing substance use or mental health treatment, a functional assessment tool is used with different modules for adults and youth age 6 to 18. Individuals seeking CCBHO services shall receive a preliminary screening and risk assessment at first contact to determine acuity of need. Emergency, urgent, or routine service needs shall be identified and addressed. Following the preliminary screening, qualified staff shall conduct an initial evaluation and further screening, and provide needed services as indicated by the initial evaluation. Additional screening shall include, but is not limited to: 1) Depression screening for all adolescents age thirteen (13) to eighteen (18) years of age; 2) Depression screening for all adults age nineteen (19) and older; 3) Suicide risk assessment for all adolescents and adults diagnosed with major depression; 4) Brief health screen, as specified by the department; 5) Alcohol use disorder screening; and 6) Substance use disorder screening.

DBH substance use treatment programs include the Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs, Substance Awareness Traffic Offender Program (SATOP), Department of Corrections (DOC) programs and State Opioid Response (SOR) programs.

The CSTAR programs are designed to provide an array of comprehensive, but individualized, treatment services with the aim of reducing the negative impacts of substance use disorders to individuals, family members and society. All but the Opioid programs offer a residential component for individuals who need that type of structure and support. Available services include assessment; individual and group counseling; group rehabilitative support; community support; peer support; family support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; and medications, physician and nursing services to support medication therapy. CSTAR features three levels of outpatient care that vary in duration and intensity, with specific services received based on individuals' needs. Persons may enter treatment at any level in accordance with eligibility criteria. A designated Program Specialist, acting as the State Opioid Treatment Authority (SOTA), provides oversight and clinical assistance to the Opioid programs to ensure that treatment is consistent with best practices and federal requirements. The CSTAR programs are targeted for specialized populations including Women and Children (9 contracts), the General Population (23 contracts), the Opioid Program (10 contracts), and Adolescents (8

contracts). DBH's CSTAR programs are the only substance use treatment programs reimbursable by Medicaid in the state. In 2011, DBH was successful in amending the Medicaid state plan to include a CSTAR Modified Medical Detoxification Program (11 contracts).

In an effort to expand residential access for consumers, the 1115 IMD waiver, currently in development and available for providers to utilize if approved, seeks to expand the current maximum capacity of 16 beds.

Additionally, CSTAR services are transitioning to the utilization of American Society of Addiction Medicine (ASAM) criteria to provide substance use services. This continuum of care, based on criteria placement, will include a shift from a fee for service pay structure to team based billing.

DBH also maintains the Primary Recovery Plus (PR+) program (6 contracts). Similar to the CSTAR General Population Program, PR+ offers a full continuum of services within multiple levels of care to assist those individuals without Medicaid coverage. DBH oversees several programs designed specifically for Department of Corrections' offenders under community-supervision who need substance use treatment. These include CSTAR Women and Children Alternative Care (2 contracts), Improving Community Treatment Success (ICTS) (6 contracts), Community Partnership (2 contracts), and Free and Clean (1 contract). In 2019, DOC received additional state funds to expand the Improving Community Treatment Success (ICTS) program to additional counties. As established in all DBH SUD contracts, priority populations for substance use treatment include:

- Women who are pregnant and have injected drugs in the prior 30 days;
- Women who are pregnant;
- Persons who have injected drugs in the prior 30 days;
- Civil involuntary commitments;
- High risk offenders referred by the Department of Corrections' institutions and Division of Probation and Parole via referral form and protocol;
- Applicants and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, Family Support Division, via referral form and protocol; and
- Adolescents and families served through the Children's System of Care.

All contracted agencies providing substance use treatment are required to screen individuals requesting services to determine potential eligibility as a priority population and/or a crisis situation. Individuals identified as a priority population who request or are referred to treatment must be assessed and admitted to an appropriate level of care within 48 hours of initial contact or scheduled release date, whichever is later. Otherwise, the provider must initiate interim services. Pregnant women and civil involuntary commitments, however, require immediate admission. Pregnant women are to be referred to a CSTAR Women and Children Program unless there is clinical justification to admit her to a general treatment program.

DBH's SATOP program is a statewide system of comprehensive, community-based education and treatment programs designed for individuals who have pled guilty or were found guilty of an impaired driving offense with administrative action. SATOP is also required for offenses for individuals under the age of 21, charged with Minor in Possession, Abuse and Lose,

and Zero Tolerance offenses. The program serves an average of 17,000 offenders annually. The mission of SATOP is to: A) inform and educate DWI offenders as to the hazards and consequences of impaired driving; B) educate youth about the risks and consequences of alcohol and drug use and help them develop skills to make healthy choices; C) motivate individuals for personal change and growth; and D) contribute to the public health and safety of Missourians by preventing and reducing the prevalence of alcohol and drug impaired driving. DBH certifies and monitors SATOP programs which offer varying levels of intervention. In order for an individual to complete SATOP requirements one must complete a drug and alcohol assessment, pay fees, and successfully complete the assigned level of education or clinical treatment services. Many factors are considered for program placement, which include: drug and alcohol history and previous substance use treatment; previous DUI/DWI history; Blood Alcohol Content (BAC) at time of arrest; and a determination of whether an individual meets diagnostic criteria for a substance use disorder. SATOP is largely funded by offender fees.

Core services for the Division of Behavioral Health's (DBH) Community Psychiatric Rehabilitation Program (CPR) (28 contracts), targeted case management (18 contracts), and supported community living are provided in a community-based and consumer-centered manner. Services provided in DBH's Community Psychiatric Rehabilitation Program (CPRP) for adults (28 contracts) and youth (23 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support, medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services with non-acute conditions who cannot be served in their own homes. Intensive CPR programs include Enhanced Psychosocial Rehabilitation (PSR), Assertive Community Treatment (ACT), Assertive Community Treatment for Transition Age Youth (ACT-TAY), Integrated Treatment for Co-Occurring Disorders (ITCD), Clustered Apartments, Intensive Residential Treatment Services (IRTS), Psychiatric Individualized Supported Living (PISL), and Inpatient Diversion. Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be a danger to themselves or others because of their mental disorder. DBH also oversees Community Mental Health Treatment (CMHT) and Offenders with Serious Mental Illness (OSMI) (28 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness. Target populations for mental health treatment include:

- Forensic clients pursuant to Chapter 552 RSMo;
- Adults, children, and youth with serious mental illness (SMI) being discharged from DBH operated inpatient facilities, being transitioned from DBH-operated or contracted residential settings, being transitioned from DBH alternatives to inpatient hospitalization; being discharged from private psychiatric hospitals;
- Adults, children, and youth at risk of homelessness;
- Children and youth referred through the Custody Diversion Protocol;
- Individuals with a clinical or personality disorder, other than a principal diagnosis of substance use or mental retardation, who also qualify as an adult with severe disabling

SMI or children and youth with serious emotional disturbance (SED), as defined by the Department.

DBH supports Assertive Community Treatment (ACT), a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring substance use diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance use, and vocational rehabilitation. DBH contracts with nine agencies to provide ACT including nine teams for adult ACT and ten teams for ACT for Transitional Age Youth (ACT-TAY).

DBH supports Integrated Treatment for Co-Occurring Disorders (ITCD), an evidence-based program treating adults for severe and persistent mental illness and substance use disorders. Services are provided by a multidisciplinary treatment team in the home or community as well as within the agency. Team members include prescribers, RNs, integrated treatment counselors and case managers all specifically trained in co-occurring treatment. ITCD services are evaluated for fidelity to the ITCD model by the department. DMH contracts with 27 community mental health agencies providing ITCD services at 48 locations.

For mental health treatment, the state is divided into 25 mental health service areas each with an Administrative Agent. By Missouri statute, these Administrative Agents are responsible for the assessment and provision of services either directly or through affiliate Community Mental Health Centers (CMHC) for individuals residing in the assigned service areas. The Administrative Agents are also required to have cooperative agreements with the state-operated inpatient hospitals and are responsible for the provision of follow-up services for persons released from the state or private psychiatric hospitals. Of the 28 CMHC's, 26 are also contracted for Health Homes which was implemented in January 2012. Of the 26 Health Homes, 15 are Certified Community Behavioral Health Organizations (CCBHO) who participated in the CCBHC Prospective Payment System Demonstration Project.

CCBHC/Os integrate behavioral health with physical healthcare, while providing a comprehensive array of services that include crisis intervention, screening, treatment, prevention, peer and family support services, and wellness services for individuals with serious mental illnesses and substance use disorders. CCBHC/Os are designed to demonstrate the cost effectiveness of converting to a prospective payment system while improving the availability, accessibility, and quality of community behavioral healthcare. The PPS is an actuarially sound cost-based reimbursement method that replaces the current Medicaid fee-for-service system, which provides reimbursement for individual units of community service provided. CCBHC/Os recognized by the DMH in substantial compliance with federal and state standards for CCBHC/Os receive a single, fixed payment amount for each day that they provide eligible CCBHC/O services to a Medicaid-eligible individual. Missouri currently has 15 CCBHC/Os that are participating in the federal demonstration. Outside of the federal demonstration, the DMH is expanding the number CCBHOs operating in the State.

For substance use treatment, individuals' access services directly from the contracted service provider and may seek services anywhere in the state regardless of their county of

residence. DBH funds ten regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for persons experiencing a behavioral health crisis. DBH has arrangements with local taxing authority boards who have a Mental Health Mil tax or Children's Services tax to fund mental health services for adults (four counties plus the city of St. Louis) and youth (four counties) and substance use treatment for adults (four counties) and youth (two counties plus the city of St. Louis). Regional offices provide consultation and technical assistance to community-based service providers and conduct regular reviews of provider systems.

DBH has implemented several programs to improve coordination of consumers' primary and behavioral healthcare. Disease Management 3700 started as a two-year collaborative demonstration project between DBH and the state Medicaid authority, MO HealthNet. Medicaid eligible individuals with serious and persistent mental illness, who are not current consumers of DMH, and who have had a minimum of $20,000 annual Medicaid claims are identified for the program. Persons successfully outreached and engaged through the project are enrolled in a CMHC or SUD treatment provider and assigned a Community Support Specialist. The Disease Management program served as a model for Missouri's Health Home initiative and the Substance Use Disorder (SUD) Disease Management. The SUD Disease Management program began in February 2014 and targets Medicaid-enrolled adults with substance use disorders and high medical costs who are not currently engaged in treatment.

The Community Mental Health Centers (CMHCs) & Federally Qualified Health Centers (FQHCs) Integration Initiative allows CMHCs and FQHCs to partner. The goals of the Integration Initiative supports collaboration between CMHCs and FQHCs to integrate behavioral health services and primary care in the public health safety net system in order to improve access to: primary care for individuals with mental illness; behavioral health services for individuals with previously unrecognized and/or untreated mental health problems; and behavioral health supports for individuals who require assistance in effectively managing their chronic disease or improving health status.

The SUD Provider & FQHC Integrated Care Pilot Project will allow Behavioral Health Providers contracted by DBH to provide CSTAR services and FQHCs to partner. The goals of the pilot project will support collaboration between FQHCs and DMH Certified CSTAR Providers to integrate primary care and substance use treatment in the public health safety net system in order to: identify substance use concerns within the primary care environment; reduce health disparities; and change (improve, create) the working relationship between primary medical and specialty behavioral health.

Missouri has two types of healthcare homes: 1) the CMHC's and 2) primary care including the Federally Qualified Health Centers, Rural Health Clinics, and Hospital-Operated Primary Care Clinics. Enrollment in the CMHC Health Homes began in January 2012. Eligible individuals must be covered by MO HealthNet and have 1) a serious and persistent mental illness, 2) a mental health condition and a substance use disorder, or 3) a mental health condition or a substance use disorder and a chronic health condition. Of those enrolled, approximately 82 percent are adults and 18 percent are children or youth. As a Health Home, the CMHC's provide comprehensive case management, care coordination and health promotion, patient and family support, comprehensive transitional care, and referrals to community and support services.

DMH also funds initiatives through the Missouri's Strengthening Mental Health Initiative aimed at reducing the unnecessary use of emergency departments for behavioral health issues and to assist law enforcement and courts to more efficiently connect people with behavioral, physical and basic needs services. Emergency Room Enhancement (ERE) initiative provides funding to fifteen regions of Missouri to reduce repeated use of emergency departments and hospitals for behavioral health concerns that would be better addressed in community settings. The fifteen regions include Kansas City, Springfield, Columbia, Hannibal, St. Joseph, St. Louis, Rolla, Poplar Bluff, Joplin, Cape Girardeau, Jefferson City, Monett, Trenton, and most recently in 2021, the newest regions, West Central and West Plains. Each of these areas have partnered with local hospitals, community mental health centers, law enforcement agencies, substance use treatment providers, and social service providers to coordinate care for the whole person by addressing behavioral, physical and basic needs. The Community Behavioral Health Liaison (CBHL) initiative originally consisted of 31 CBHLs, but due to the tremendous success of the program, 50 additional positions were added in 2021. CBHLs are employed by behavioral health provider organizations across the state to assist law enforcement and courts to form better community partnerships between treatment providers, law enforcement, jails, and courts. This programs saves valuable resources that might otherwise be expended on unnecessary jail, prison, and hospital stays, and improve outcomes for individuals with behavioral health issues. Liaisons also follow-up with Missourians referred to them in order to track progress and ensure success. Through the CBHL program, people with behavioral health issues who have frequent interaction with law enforcement and the courts will have improved access to behavioral health treatment.

Psychiatric Facility Operations

Facility Operations includes management and oversight of the six state-operated psychiatric facilities – one for children and five adult hospitals. With limited exceptions, state operated facilities for adults provide hospital treatment for individuals referred by the criminal courts for competency restoration and as Not Guilty by Reason of Mental Disease or Defect or referred by the probate court as Missouri's Sexually Violent Predator Act. Adult facilities are located in St. Louis, St. Joseph, Fulton, Kansas City, and Farmington. The youth facility is located in St. Louis. Currently, there are 869 adult psychiatric inpatient, 53 adult psychiatric residential, 28 child and youth psychiatric inpatient, 16 youth psychiatric residential, 287 sexual offender inpatient and 16 sexual offender residential beds.

Forensic services provides evaluation, treatment, competency restoration, and community monitoring under the order of the circuit courts for individuals with mental illness and developmental disabilities involved in the criminal justice system. DBH provides three levels of security (high, minimum, and campus), with the desired goal of progressive movement through the security continuum based on clinical condition and risk assessment. Within this continuum, forensic clients are provided treatment in a setting consistent with both the clinical needs of the client and safety of the public. Forensic programs are located at Southeast Missouri Mental Health Center, St. Louis Forensic Treatment Center - South, Northwest Missouri Psychiatric Rehabilitation Center, and Fulton State Hospital. Forensic Case Monitors provide community monitoring, as required by state statute, to forensic clients acquitted as not guilty by reason of mental disease or defect who are given conditional releases by circuit courts. There are approximately 400 forensic clients on conditional release statewide.

Children's Services

Both substance use and mental health services for children are coordinated under the Department of Mental Health Children's Director. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbance (SED). These community-based services are designed to maximize independent functioning and promote recovery and self-determination. A statewide assessment tool quickly identifies where outcomes are needed so clinicians/community support specialists can address those areas on the individualized treatment plan with the goal of improved functioning and symptom reduction. An assigned Community Support Specialist monitors medical, dental, and support service needs and coordinates services and resources among community agencies. The CPR program includes an intensive level of care for acute psychiatric episodes as clinically appropriate. Approximately 80 percent of the youth receiving mental health treatment are in the CPR program. Community support services available to children and youth include day treatment, psychosocial rehabilitation services, intensive/non-intensive targeted case management, community support, respite, family support, and family assistance. Day treatment provides goal-oriented therapeutic services focusing on the stabilization and management of acute or chronic symptoms, which have resulted in functional deficits. Day treatment may include physician services, psychiatric evaluations, medication management, age appropriate education services, skill building groups, individual and group psychotherapy, occupational/physical therapies, community support, and family support. Psychosocial rehabilitation services are a combination of goal-oriented and rehabilitative services provided in a group setting. Family support helps establish a support system for parents of children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. With family assistance, a Family Assistant Worker may work with the individual and family on home living and community skills, communication and socialization, and conflict resolution.

In 2020, the youth peer support service was added to the CPR Program. Youth Peer Support Specialists support, encourage, and model positive self-advocacy, recovery and resiliency. The Division of Behavioral Health (DBH) requires all Youth Peer Support Specialists providing services to youth under the age of 18 to be certified in youth peer support. A nationally recognized training curriculum is utilized and a competency exam is required.

In 2012, Professional Parent Home (PPH) services were added to the CPR array of services offered to youth. The youth served in PPH have serious emotional needs which often result in behaviors that precipitate placement in restrictive residential or inpatient settings. PPH exists to serve these youth in a private home designed to be a therapeutic environment to avoid such restrictive placement. PPHs consist of trained and qualified professionals serving only one child at a time in their home, due to the severity of the child's needs. The parenting role is the sole employment for these parents. They are required to complete 40 hours of basic training as well as an enhanced training package. These youth have demonstrated an inability to be in the community free of emotional or physical difficulty and who, without a sustained intensive therapeutic intervention, would have significant physical, emotional, or relational consequences. PPH providers are responsible for participation in the development of the youth's treatment plan and record documentation related to implementation of the treatment plan within the home. Treatment Family Homes (TFH) are a less restrictive version of the PPH model. Up to three children may be

placed in each TFH and, TFH parents are trained and qualified individuals who work with children in their own home. The goal of this service is to reunite children with their families whenever possible.

In 2013, DBH offered an introductory training to providers across the state on a specialized Assertive Community Treatment (ACT) service targeted for the transitional age youth (ages 16-25) population. The first Missouri Assertive Community Treatment Transition Age Youth (ACT TAY) program was developed in the Central Region and began providing services to this population in January 2014. The ACT TAY program uses a team approach designed to provide comprehensive and flexible treatment, support, and rehabilitation services to transition age youth in their natural living settings rather than in hospital or clinic settings. The multi-disciplinary team members include a physician, nurse, vocational specialist, substance use specialist, peer specialist and community support specialist. Missouri has ten ACT TAY programs.

For children and youth, the first signs of mental illness or emotional distress can emerge in the school environment. DBH has expanded the availability and accessibility of treatment services by authorizing the delivery of designated CPR services in school settings. These designated CPR services are provided to children with an Individualized Education Plan (IEP) or a 504 plan as well as youth without a formal plan who are determined to need additional support due to behavioral health issues. DBH providers partnering with schools is effective because it enables specialists to quickly identify student issues and immediately triage care based on the severity of circumstances. In addition to students getting immediate assistance, school personnel benefit from having CPR services provided in the school setting.

Substance use treatment for adolescents is provided in the CSTAR Adolescent program. Designed for youth age 12 to 17, the CSTAR Adolescent program offers a full spectrum of treatment services. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Youth in residential settings are offered academic support services to minimize disruptions in their education. For youth with co-occurring mental health and substance use disorders, treatment services are provided through coordination of care between youth Community Psychiatric Rehabilitation and CSTAR adolescent programs. Multiple domains of the youth's life are addressed including family, school, employment and social support. The Assertive Community Treatment for Transitional Age Youth (ACT TAY) model for ages 16-25, utilizes a trans-disciplinary approach to provide a comprehensive array of services to address both mental health and substance use.

The Department of Mental Health (DMH) is partnering with the Department of Social Services (DSS) to support the successful roll out and implementation of the Family First Preservation Services Act in Missouri. The federal child welfare legislation passed in 2018 and slated for implementation in Missouri in October 2021, is designed to enhanced prevention services and help children remain safely in their homes to avoid the traumatic experience of being separated from their family. One component of this transformative legislation requires that an independent assessment must be completed by a qualified clinician for youth entering DSS custody to determine if the youth's needs could be met with community-based services while living with a relative or resource family, or if residential treatment is the most effective and appropriate short-term placement. DBH providers have partnered with DSS to establish "Independent Assessors" within each Judicial Circuit, with the goal of keeping community-based

services as close to youth and caregivers as possible. DBH providers will also centrally track the referrals, assessments, and outcomes for this process.

The Department of Mental Health (DMH) continues to partner with the Department of Social Services (DSS) to provide resources and options to parents who are considering voluntarily relinquishing custody for the sole purpose of accessing mental health treatment for their child. For those children already in state custody solely for mental health services in the absence of child abuse or neglect and severe intellectual/developmental disability, DMH and DSS have facilitated an evaluation and review process. DSS' Children's Division has established Family Support Teams for children identified to determine future custody status. In conjunction with the diversion protocol, voluntary placement under Title IV-E allows a family to relinquish physical custody but retain legal custody so that these children become eligible for mental health services funded by Medicaid and Title IV-E funds for a period of up to 180 days. System of Care Expansion Grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) has supported the expansion of local interagency teams to oversee children's services in the community and promote earlier identification and intervention services. Missouri currently has 30 local System of Care (SOC) teams.

Recovery Supports

The Division of Behavioral Health's (DBH) Recovery Services includes housing, employment, peer services, staff training and development, and coordination of the DBH state advisory council. The Director of Recovery Services oversees DBH's housing unit who works to connect homeless individuals who are challenged with behavioral health issues with safe, decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 27 U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) Permanent Support Housing (PSH) grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness, a chronic substance use problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, and 3) meet the "very low" income requirement. Approximately 3,000 persons are served annually through Missouri's Shelter Plus Care program. Missouri has ten federally-funded Projects for Assistance in Transition from Homelessness (PATH) grants to support service delivery to adults (age 18 or older) with serious mental illness, as well as those with co-occurring substance use disorders, who are homeless or at risk of becoming homeless. Services include community-based outreach; support services such as case management, employment skills training, psychosocial education, and group therapy; and some temporary housing services. Supported community living programs are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. Persons in these programs receive support through case management and community psychiatric rehabilitation programs provided by administrative agents.

DBH recognizes the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual in competitive employment to promote stable employment. Missouri uses the Individualized Placement and Support (IPS) model to fidelity. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (VR) who provides job counseling, job-seeking skills, job placement, and

vocational training. DBH also provides support services for mental health clients not currently eligible or ready for services from VR. The Department of Mental Health (DMH) provides ongoing benefits planning training materials and a web-based tool "Disability Benefits 101". DBH staff developed guidance documents on appropriate community support interventions reimbursable under the CPR and CSTAR treatment programs for consumers pursuing employment (DMH, 2012). DMH has 32 community behavioral health locations designated as VR funded Community Rehabilitation Programs to provide evidence based supported employment services.

In 2018, DBH began certifying Recovery Support Services providers for care coordination, peer recovery coaching, spiritual counseling, group support, recovery housing and transportation before, during, after and in coordination with other substance use disorder service providers. These services are offered by 53 certified Recovery Support Service providers in a multitude of settings including community, faith-based and peer recovery organizations. Recovery Support programs are person-centered and self-directed. Recovery Housing certification requires the provider to also obtain accreditation through the Missouri Coalition of Recovery Support Providers/National Alliance of Recovery Residences (NARR). Currently, 151 Recovery Houses with over 1,360 beds are accredited. DMH receives a SAMHSA State Opioid Response (SOR) grant for the purpose of expanding access to integrated prevention, treatment, and recovery support services for individuals with opioid use disorder throughout the state, including development of local Recovery Community Centers (RCC). Four RCCs provide a peer-based supportive community that builds hope and supports healthy behaviors for individuals with Opioid Use Disorders (OUD) and Stimulant Use Disorders searching for or maintaining recovery.

Peer services are available to individuals in behavioral health treatment and recovery to aid in the navigation of Medicaid programs and establish linkages to other community resources. Missouri currently has over 1000 actively Certified Peer Specialists whom work at Community Mental Health Centers, Substance Use Treatment Programs, state-operated hospitals, and recovery support services. DBH funds through competitive bid four consumer-operated drop-in centers that emphasize self-help for individuals with mental illness. Family Support Provider is a peer to peer service that provides support to parents/caregivers who have children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance.

The DBH SAC includes two standing committees, the Mental Health Disorders Committee and the Substance Use Disorders Committee. The purpose of these committees is to ensure adequate representation and focus on the issues unique to each committee. The co-chairpersons of these standing committees equally share the leadership of the full SAC. Meetings typically include budget and programming updates from DBH staff as well as in-depth presentations and discussions on initiatives and strategic planning. Members have professional, research, and/or personal interests in the respective area. Membership on the SAC must be at least one-half individuals with lived experience of recovery and/or family members and have at least one member representing veterans and military affairs. Current membership includes representation from the Departments of Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing, Mental Health, Health and Senior Services, vendors, and people with lived experiences. The February and June 2021 meetings reviewed and approved a draft of the FY 2022 – 2023 Block Grant Behavioral Health State Plan.

Prevention and Mental Health Promotion

Prevention and Mental Health Promotion includes substance use prevention, opioid overdose prevention, tobacco retailer education, Mental Health First Aid, veteran's services suicide prevention and crisis services. DBH contracts with 10 community-based Prevention Resource Centers (PRC) that are state-certified to provide prevention services on alcohol, tobacco, and other drug issues. The PRC's are the primary source of training and technical assistance support for over 178 community coalitions located throughout the state. The coalitions are teams of volunteers of community leaders, parents, and youth who seek to address substance use in their communities. The PRC's employ prevention specialists that serve as community-level experts to assess community needs, build capacity, develop strategic plans, and implement evidence-based prevention programming. Opioid overdoses have greatly impacted Missouri, especially in the St. Louis region. DBH has received federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide prevention, treatment and recovery services in response to the Opioid Crisis.

The Director of Prevention and Mental Health Promotion is also the project coordinator for the state's FDA tobacco enforcement contract. .The PRC's provide retailer education on state and federal tobacco regulations to local tobacco retailers and assist the state in compiling a list of tobacco retailers in support of federal Synar requirements, as Missouri does not have tobacco licensure. DBH subcontracts with the Department of Public Safety, Division of Alcohol and Tobacco Control for enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DBH also provides funding to Partners in Prevention (PIP), Missouri's higher education substance use consortium representing 24 colleges and universities and serving about 191,000 college students. PIP administers the Missouri Assessment of College Health Behaviors (MACHB) which is completed by approximately 10,000 students each school year. The PRC's, PIP, and many community coalitions have been trained on and use SAMHSA's Strategic Prevention Framework planning process. In support of prevention planning at the local level, DBH funds the biennial Missouri Student Survey (MSS) to assess substance use and related behaviors among students in grades 6 through 12.

DBH's School-based Prevention, Intervention, and Resources Initiative (SPIRIT) implements school-based curricula of proven effectiveness for reducing substance use, preventing substance initiation, and reducing violent behavior among children in kindergarten through 12th grade. Age- and grade-appropriate programs are selected from SAMHSA's National Registry of Evidence-based Programs and Practices. SPIRIT currently operates in four sites serving 13 school districts across the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided. In FY 2021, about 10,400 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.

DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern

Missouri known as the "Bootheel". DBH contracts with the Missouri Alliance of Boys and Girls Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) and MethSMART. In Fiscal Year 2021, 3,433 high risk youth were served in prevention programs funded through DBH. DBH contracts with DeafLEAD for the provision of prevention services for deaf and hard of hearing youth. DeafLEAD conducts the annual Teen Institute for the Deaf attended by approximately 30 youth ages 12 to 17.

In 2010, Missouri established an interagency Statewide Epidemiology Outcomes Workgroup (SEOW) through funding support from SAMHSA. Missouri's SEOW is chaired by an Epidemiologist at the Missouri Institute for Mental Health – University of Missouri, St. Louis. The core group comprises of the four epidemiologist funded through the state (1) and community (3) Partnership for Success grantees. Additional feedback is gathered from the Department of Mental Health and other stakeholders as appropriate. Missouri's SEOW mission is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

DBH partners with the National Council for Mental Wellbeing to implement Mental Health First Aid (MHFA). MHFA is a program that teaches the public how to recognize the signs and symptoms of mental health problems. Over 37,000 individuals have taken the MHFA adult course in Missouri and 22,000 adults who work with youth have received MHFA youth training. An instructor course is also available for individuals seeking instructor certification. Over 350 individuals have been certified as MHFA instructors in Missouri.

With federal grant funding, Department of Mental Health has been able to increase suicide prevention efforts in the state. Efforts have included Zero Suicide and other evidence-based trainings, school and emergency room interventions, and statewide public education for adults and youth. In 2018, DBH partnered with the Council for Behavioral Healthcare to create the Missouri Suicide Prevention Network to lead and coordinate statewide suicide prevention efforts. In 2021, Missouri Suicide Prevention Network updated Missouri's State Suicide Prevention Plan. The three priorities of the State Suicide Prevention Plan are to fully embrace a public health approach to suicide prevention, establish Missouri as a Zero suicide in Healthcare state and develop a robust data collection and reporting system.

In 2012, DMH hired a Project Manager to oversee behavioral health services for Missouri's veteran population. The Veteran's Services Director This position manages the statewide policy development, implementation and operation of supportive services for service members, veterans and their families. This includes coordinating federal (Veterans Administration), state agencies and community behavioral health programs ensuring the military community (service members, veterans and their families) has access to timely, quality services. The position analyzes behavioral health systems, develops strategies, program development, project management and administrative of behavioral health supportive services; workforce development; raising public awareness of the Military Community's needs and educating

Missourians on how to connect with appropriate services. Missouri is one of thirty-seven states participating in the Governor's Challenge to Prevent Suicide Amongst Service Members, Veterans, and their Families. DBH created a state team consisting of federal, state and community partners working to develop and implement state-wide suicide prevention best practices for Service Members, Veterans and their Families, using a public health approach. This national initiative is a partnership through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs (VA).

DBH has made considerable strides in aligning our crisis system with SAMHSA's guidelines and best practice considerations for crisis services. DBH echoes the sentiment that crisis services should be available to anyone, anywhere, and at any time. To achieve a comprehensive crisis continuum that is equipped to meet the needs of individuals throughout the state, we are prioritizing the enhancement, alignment, and coordination of these community crisis components:

- 988 and Access Crisis Intervention (ACI) Services (*Someone to talk to*)
- Mobile Crisis Response Services (*Someone to respond)*
- Crisis Receiving and Stabilization Services (*Someplace to go*)

National mental health leaders recognized the overwhelming need for people experiencing a mental health crisis to connect to services more easily. 988 was recently designated as the national 3-digit phone number for individuals experiencing a mental health crisis. By dialing 988, individuals in crisis will receive suicide prevention and mental health support through connection with a trained crisis counselor. DBH received a state planning grant to prepare for 988 rollout on July 16, 2022, and the years following. Over the past few years, Missouri has expanded its National Suicide Prevention Lifeline members from three to six, with an additional member pending. These centers will be responsible for handling all 988 calls, chats, and texts that occur in the state. Missouri is leading a 988 Task Force that is made up of behavioral health leaders and advocates who are coming together to plan and prepare for 988 implementation. Planning elements include meeting, maintaining, and improving capacity, funding, and infrastructure to achieve better outcomes for Missourians in crisis. With 988 highlighting the opportunity for expansion of crisis care in Missouri, DMH is partnering with Council for Behavioral Healthcare and other stakeholders to achieve operational, clinical, and performance consistency to ensure significant connection and continuity of care across the state. Missouri stakeholders are placing particular emphasis on attaining a more equitable and community-oriented crisis response by responding to wherever the crisis occurs.

DBH also funds ten regional Access Crisis Intervention (ACI) Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for persons experiencing a behavioral health crisis. providers currently provide mobile crisis response services. Each provider is required to provide mobile crisis response services to all individuals; however, in some instances, billing and intake challenges result in only CCBHO/CMHC enrolled members receiving mobile crisis response, limiting access for many Missourians. The national focus on crisis services presents the opportunity to expand a community-based mobile crisis response system that responds to individuals wherever they are experiencing a crisis. DMH and stakeholders are working diligently to address gaps and improve this component of crisis services.

For crises that warrant medical stabilization, Crisis Stabilization Units may serve as an appropriate alternative to hospitalization. DBH is supporting the development of additional units that provide prompt assessment, medical monitoring, stabilization, and determination of the next level of care needed and are considered less restrictive than traditional inpatient psychiatric services. DBH is supporting the development of additional Crisis Stabilization Units that provide prompt assessment, medical monitoring, stabilization and determination of next level of care needed and are considered less restrictive and an alternative to traditional inpatient psychiatric hospitalization.

Disaster Services

The Department of Mental Health's (DMH) Office of Disaster Services (ODS) conducts planning and development activities to support a coordinated mental health response for Missourians in disaster situations. ODS coordinates efforts with the State Emergency Management Agency (SEMA), the Department of Health and Senior Services, other state agencies and voluntary agencies active in disaster (VOAD). ODS also develops and administers the FEMA/SAMHSA Crisis Counseling Program (CCP) grant when there is a federal declaration in Missouri. ODS coordinates the DMH Show-Me Response network that deploys, in the event of a disaster, volunteers of licensed professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, certified substance use treatment counselors, and developmental disability professionals, and non-licensed disaster behavioral health strike team members. ODS represents DMH on the Governor's Faith-Based & Community Service Partnership for Disaster Recovery and the Missouri VOAD to aid Missourians' recovery plans by developing and implementing a holistic approach to disaster recovery.

Administration

The Division of Behavioral Health's (DBH) administration unit includes budgetary/financial analysis and monitoring, grants management, the Customer Information and Management Outcomes and Reporting (CIMOR) Help Desk, and Research and Statistics. Process measures and client outcomes data are generated for program monitoring and federal reporting. DBH produces an annual Status Report on Missouri's Substance Use and Mental Health Problems that provides epidemiological profiles of the state, its counties, and planning regions. In FY 2018, DBH published its 24th edition of the annual status report and, in collaboration with the state epidemiology workgroup, has implemented a web-based querying tool to facilitate use of behavioral health data at the local level.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Assessment of Need

Behavioral Health Data

The Missouri Department of Mental Health (DMH) utilizes prevalence data, behavioral health indicators, treatment admissions data, population estimates, needs assessments, and outcomes data for planning purposes. DMH assimilates behavioral health-related data from several national and state surveys. DMH acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavior Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS) for grades 6 through 12, and state data collected from 21 of Missouri's universities and colleges using the Missouri College Health Behavior Survey (MCHBS). DMH annually updates prevalence estimates using the most current survey data.

DMH collects an array of behavioral health indicator data, mostly from other state agencies. The indicators include traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; substance positive births; substance-induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements; methamphetamine lab confiscations; probation, parole, and prison admissions; drug overdose deaths; suicide rates; and drug, DUI, and mental health court enrollments. DMH also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment rates. On an annual basis, DMH assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, service areas, planning regions, and the state.

Substance use and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Information on demographics, substances used, diagnoses, and treatment services are assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and state. These profiles are included in DMH's annual Status Report on Missouri's Substance Use and Mental Health Problems.

State Epidemiology Outcomes Workgroup

In 2010, Missouri was awarded a State Epidemiology Outcomes Workgroup (SEOW) contract, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state used this funding to revitalize its SEOW workgroup that had been established under the Strategic Prevention Framework State Incentive Grant (2004-2009) to address underage drinking. The mission of Missouri's current SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and it's communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

The SEOW is chaired by an epidemiologist at the Missouri Institute for Mental Health – University of Missouri, St. Louis. The core group comprises of the four epidemiologist funded through the state (1) and community (3) Partnerships for Success grantees. Additional feedback is gathered from the Department of Mental Health and other stakeholders as appropriate.

As part of the SAMHSA-funded Partnership for Success 2020 Grant (2020-2025), the SEOW has been responsible for providing data expertise and support to Partnership sub-recipients in reducing risk factors and promoting protective factors common to alcohol, tobacco, and other drug use, including development of a methamphetamine data collection tool. As part of the broader behavioral health system, the SEOW workgroup continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations.

Overall Need

Serious Emotional Disturbance (Children) and Serious Mental Illness (Adults)

Sub-state Planning Area	2019 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2020	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	493,562	34,550	6,370	28,180	81.56%
Eastern	504,478	35,314	6,000	29,314	83.01%
Southwest	217,001	15,191	4,687	10,504	69.15%
Southeast	155,544	10,889	3,269	7,620	69.98%
State Total	1,370,585	95,941	19,573	76,368	79.60%

Table 1. FY 2020 Estimated prevalence of childhood serious emotional disturbance.

Sub-state Planning Area	2019 Population Age 18+	Estimated Need (5.56%)	Received Treatment FY 2020	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	1,680,906	93,459	21,997	71,462	76.46%
Eastern	1,774,434	98,659	18,700	79,959	81.05%
Southwest	748,331	41,608	9,249	32,359	77.77%
Southeast	542,363	30,156	10,564	19,592	64.97%
State Total	4,766,843	265,037	58,351	206,686	77.98%

Table 2. FY 2020 Estimated prevalence of adult serious mental illness.

State estimates for serious mental illness (SMI) (adults) and serious emotional disturbances (SED) (children) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Based on these historically reported estimates, approximately 5.4 percent of the Missouri adult population has an SMI and 7 percent of Missouri children have an SED. Based on NSDUH data, 5.56 percent of Missouri adults have an SMI (SAMHSA, 2020). A study by Mark and Buck (2006) examining characteristics of U.S. youth with SED found that about 44 percent were covered by private insurance, 31 percent were enrolled in Medicaid/Children's Health Insurance Program (CHIP), 11 percent were covered by another unspecified public program, and about 14 were uninsured. It is reasonable to assume that the majority if not the entire uninsured group represents unmet need. It is not known what portion of the private insurance group did not have sufficient coverage for adequate care of the child's SED condition.

Substance Use Disorder

Sub-state Planning Area	2019 Population Age 12-17	Estimated Prevalence (4.80%)	FY 2020 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	167,268	8,029	590	7,439	92.65%
Eastern	172,908	8,300	579	7,721	93.02%
Southwest	74,558	3,579	383	3,196	89.30%
Southeast	54,138	2,599	273	2,326	89.50%
State Total	468,872	22,507	1,825	20,682	91.89%

Table 3. FY 2020 Estimated prevalence of adolescent substance use disorder.

Sub-state Planning Area	2019 Population Age 18+	Estimated Prevalence (7.71%)	FY 2020 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	1,680,906	129,598	14,532	115,066	88.79%
Eastern	1,774,434	136,809	14,148	122,661	89.66%
Southwest	748,331	57,697	8,349	49,348	85.53%
Southeast	542,363	41,817	6,039	35,778	85.56%
State Total	4,766,843	365,921	43,068	322,853	88.23%

Table 4. FY 2020 Estimated prevalence of adult substance use disorder.

County-level population of persons age 12 or older was obtained from the Missouri Census Data Center and aggregated to the sub-state areas (Missouri Census Data Center, 2021). Statewide estimates for substance use disorder treatment need are obtained from the National Household Survey (NSDUH) (SAMHSA, 2020). The difference between estimated need and number served yields the combination of estimated served outside of the state system and unmet need.

Coordination of Primary Care and Behavioral Health Services

Individuals with serious mental illness die 11 to 32 years prematurely from preventable chronic health conditions such as heart disease, diabetes, cancer, pulmonary disease, and stroke (National Institute on Mental Health, 2012). In addition, individuals with co-occurring mental illness and substance use disorders are at greater risk for relapse and tend to have poorer outcomes in comparison to individuals with only a substance use disorder (Compton, W.M., Cottler, L.B., Behn-Abdallah, A., & Spitnagel, E.L., 2003; Hser, Y.I., Evans, E., Teruva, C., Huang, D., & Anglin, M.D., 2007; Daigre, C., Rodriguez, L. Roncero, C., Palma-Alvarez, R.F., et al., 2021). Expenditures for co-occurring individuals on Medicaid tend to be higher because of not only the substance use and mental illness disorders but also accompanying physical disorders (Clark, R.E., Samnaliev, M., & McGovern, M.P., 2009). The Missouri Department of Mental Health (DMH) has implemented a Health Home model for its Community Mental Health Centers (CMHC) and disease management programs for both serious mental illness and substance use disorders. Under the Health Home model, individuals with serious mental illness served by the CMHC's have monitoring of their health status; coordination of their care including their physical health needs; individualized care planning; and promotion of self-management. For an individual to be eligible for enrollment in Missouri's Health Home, he/she must meet one of the following three conditions:

1) have a serious and persistent mental illness,
2) have a mental health condition and a substance use disorder, or
3) have a mental health condition or a substance use disorder and one other chronic health condition.

DMH's disease management programs target Medicaid-enrolled adults with serious mental illness or substance use disorders and high medical costs who are not currently engaged in behavioral health treatment.

Crisis Intervention

Individuals experiencing a crisis due to a behavioral health condition often visit the emergency room or have contact with law enforcement or other first responders. In 2018, Missouri had over 55,000 emergency room visits in which the primary diagnosis was for a mental illness. Additionally, in Missouri roughly 33,000 emergency room visits in which the primary diagnosis was for alcohol and/or drug use (Smith, R. *et al*, 2020). Research suggests that about 7 percent of all police contacts in urban settings involve a person experiencing mental illness and up to 60-90% of police report responding to a call involving mental illness at least once per month (Hacker, R.L., & Horan, J.J., 2019). In a random sample of 500 recent admissions to Missouri's penal institutions, about one-half (48 percent) were assessed with serious functional impairment due to a substance use disorder and 14 percent were under clinical care for a mental illness (Missouri Department of Mental Health, 2015). DMH has implemented several projects: 1) Community Behavioral Health Liaisons, 2) Emergency Room Enhancement Projects, 3) Crisis Intervention Team (CIT), 4) Access Crisis Intervention (ACI) hotlines and 5) Crisis Stabilization units with the goals of increasing access to treatment and improving individual outcomes. DMH also has a 988 Planning Grant and is working with stakeholders to prepare for 988, particularly around increasing capacity and enhancing training protocols.

Department of Corrections Community Supervised Offenders

Substance Use

Sub-state Planning Area	FY 2020 Probation and Parole Population	Probation and Parole Need (64%)	FY20 Served	Estimated Unmet Need	Penetration Gap
Western	32,607	20,050	3,947	16,103	80.31%
Eastern	24,773	15,503	3,301	12,202	78.71%
Southwest	20,097	13,432	2,743	10,689	79.58%
Southeast	15,457	10,358	1,899	8,459	81.67%
State Total	91,933	58,539	11,694	46,845	80.02%

Table 5. Estimated need for substance use treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2020 was obtained from the Missouri Department of Corrections (DOC). Estimated need for substance use treatment was determined from the DOC Substance Abuse Classification Assessment (SACA). Most individuals receive an assessment when they enter prison and when they start community supervision. Number served in the publicly-funded system for FY 2020 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not receive treatment.

Mental Illness

Sub-state Planning Area	FY 2020 Probation and Parole Population	Probation and Parole Need (21%)	FY20 Served	Estimated Unmet Need	Penetration Gap
Northwest	32,607	7,086	2248	4,838	68.28%
Central	24,773	4,435	1,056	3,379	76.19%
Eastern	20,097	4,569	1190	3,379	73.95%
Southwest	15,457	3,201	903	2,298	71.79%
Southeast	91,933	19,138	5,351	13,787	72.04%
State Total	32,607	7,086	2248	4,838	68.28%

Table 6. Estimated need for serious mental illness treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2018 was obtained from the Missouri Department of Corrections (DOC). Estimated need for mental illness treatment was determined from the mental health needs score. Number served in the publicly funded system for FY 2020 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not receive treatment.

Tobacco Prevention / Cessation

Past Month Cigarette Use for Selected Groups	Missouri	U.S.
Youth Age 12-17	5.09%	4.01%
Young Adults Age 18-25	27.52%	25.08%
Older Adults Age 26+	25.88%	22.68%

Table 7. Prevalence of Current Cigarette Use (SAMHSA, 2020)

Estimates of past month cigarette use were obtained from the National Household Survey on Drug Use and Health (SAMHSA, 2020). Prevalence of cigarette use for Missouri tends to be higher than that for the U.S.

Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Department of Mental Health - Division of Behavioral Health (DBH) is the state agency that oversees the state's federal Synar requirements and partners with the Department of Public Safety – Division of Alcohol and Tobacco Control for tobacco control efforts. Federal Synar regulations require all states to maintain a retailer non-compliance rate of no more than 20 percent (42 U.S.C. 300x-26 and 45 C.F.R. 96.130). Since 1996, DBH is charged with overseeing the Synar requirements in Missouri, conducting the annual Synar survey, and implementing tobacco prevention activities as it relates to the sale of tobacco products to minors. A state that fails to comply with the federal

Synar requirements is at risk for losing Substance Abuse Prevention and Treatment Block Grant funding.

Recovery Support Services

Substance Use

Research has shown that, for many individuals, recovery coaching, 12-step programs, spirituality, and social and community supports play an important role in maintaining long-term recovery from substance use disorders (Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., *et al*., 2019). DBH funds peer support services for individuals in substance use treatment and recovery services. These services are individual or group services with a rehabilitation and recovery focus. Peer support services have shown to be highly effective in engaging individuals in services who might otherwise be reluctant to seek treatment. In FY 2020, 4,734 individuals in substance use treatment received peer support services and 2,383 received peer support in Recovery Support Services.

Missouri DBH funds four Recovery Community Centers through the State Opioid Response Grant. DBH is currently awarding four additional RCC contracts with the SABG supplemental funding. RCCs are independent, non-profit organizations that help individuals recovering from substance use disorders. They help build recovery capital by providing advocacy training, recovery information, mutual-help or peer-support groups, social activities, and other community-based services. In 2020, Missouri RCCs served over 18,000 individuals despite facing struggles due to COVID-19. More than 9,000 of those served were individuals with an Opioid Use Disorder (OUD). In 2020, 478 individuals utilized employment assistance services in the RCCs.

Serious Mental Illness

For the provision of behavioral healthcare to individuals with severe mental illness, research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Research shows that the combination of consumer-run services and community treatment services increased consumer empowerment and reduced self-stigma among participants (Segal, S.P., Silverman, C.J., Temkin, T. L, 2013). DMH funds four drop-in centers. Consumer-operated services programs (COSP) are peer-run service programs that are administratively controlled and operated by mental health consumers and emphasize self-help as their operational approach.

Drop-In Centers are a safe place where consumers can go to find recovery programs and services provided by their peers. They offer a wide variety of services including recovery focused support groups, life enhancement skills, goal setting, problem solving, computer and internet access as well as socialization with others in recovery. Anyone with a mental health diagnosis or who is or

has experienced symptoms of a mental illness is welcome to participate in services. All services are self-directed and free of charge.

Certified Missouri Peer Specialist training began in 2008 in Missouri. After researching peer support training curricula, the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) made the recommendation for the Appalachian Consulting Group "Georgia Model" which was subsequently adopted by the Division of Behavioral Health. The Department of Mental Health (DMH) is moving the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumers as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the "lived experience" as is done with any other credential or knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools, and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.

In March 2018, DBH integrated the Certified Missouri Peer Specialists (CMPS) certification with the Missouri Recovery Support Specialist – Peer certification to create the Certified Peer Specialist credential. The weeklong training is conducted by trained individuals with lived experience of recovery. Over 1000 individuals are currently active Certified Peer Specialist (CPS). CPSs are employed around the state providing services in community mental health centers, recovery support services, recovery community centers, consumer operated service programs (Drop-In Centers), the Veteran's Administration, substance use disorder treatment providers, the State Opioid Response Engaging Patients in Care Coordination (EPICC), as well as five of our state operated psychiatric facilities. The Medicaid reimbursement rate is comparable to that of a Community Support Specialist and continues to be utilized among Missouri providers.

Medication Assisted Treatment for Substance Use Disorder

Sub-state Planning Area	FY 2020 Number Served who Had an Alcohol and/or Opiate Use Disorder	FY 2020 Number who Received MAT Services	% Received MAT Services
Western	8,251	2,447	29.66%
Eastern	10,664	5,442	51.03%
Southwest	4,803	1,651	34.37%

Southeast	3,461	1,531	44.24%
State Total	27,179	11,071	40.73%

Table 8. Number served in state system with an Opioid or alcohol use disorder identified as the primary, secondary, or tertiary substance use disorder and the number who received MAT services including methadone, Vivitrol, naltrexone, buprenorphine-containing medications, Antabuse, and acamprosate.

Medication assisted treatment (MAT) is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance use disorders. DMH fully supports the use of evidence-based practices in substance use treatment, which includes MAT. DMH funds Opioid Treatment Programs (OTP) that are certified to provide methadone maintenance treatment at fifteen locations in Missouri. In addition, DMH began introducing new medications into its non-Opioid treatment programs in 2006 as part of a Robert Woods Johnson Advancing Recovery Grant. Medication services were added to treatment contracts in 2007. In 2010, Missouri began credentialing for a MAT specialty. DMH continues to expect providers to use MAT when clinically indicated. Missouri's efforts in expanding the use of evidence-based practices for the treatment of opioid use disorder (OUD), including the use of substance use treatment medications, was considerably enhanced with the federal opioid crisis grants. These grants have helped increase the pace and scale of EBP adoption and gave rise to Missouri's "Medication First" approach to treating OUD. The National Quality Forum indicated that that better outcomes are associated with pharmacotherapy. (National Quality Forum, 2019). Currently, the State Opioid Response grant contracts with 26 MAT providers, including Opioid Treatment Programs in order to increase access to MAT for uninsured or underinsured individuals with an OUD. The goal of SOR's treatment efforts are to increase access to medication for OUD through provider training, direct service delivery, and telemedicine formats. In FY 20, the treatment of stimulant use disorder with SOR funding became allowable. Six SOR treatment providers with higher rates of individuals presenting with a stimulant use disorder were awarded contracts that provided needed funding for stimulant use disorder treatment with the incorporation of contingency management.

Community Advocacy and Education

Substance Use

Approximately 377,000 Missourians have a substance use disorder (SAMHSA, 2020). Alcohol, tobacco, and other drug (ATOD) use are impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the substances. Missouri's approximately 178 community coalitions; the ten Prevention Resource Centers; and Missouri's higher education substance use consortium, Partnerships in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Prevention Resource Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.

	Missouri	U.S.
Nonmedical Use of Pain Relievers in Past Year, Age 12+	3.70%	3.58%
Alcohol Use in Past Month, Age 12-17	9.19%	9.19%
Tobacco Use in Past Month, Age 12+	24.19%	21.28%

Table 9. Estimates of Substance Use (SAMHSA, 2020)

Some issues facing Missouri's communities include: 1) methamphetamine imported from out of state; 2) prescription drug misuse; 3) underage drinking, and 4) continued availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole. Approximately 3.70% of Missourians age 12 or older engage in nonmedical use of pain relievers in the past year (SAMHSA, 2020). Current use of tobacco by Missourians age 12 or older is 24.19 percent – higher than that for the United States (21.28%) (SAMHSA, 2020).

Mental Illness

	Age 12-17		Age 18+	
	Missouri	U.S.	Missouri	U.S.
Serious Mental Illness in the Past Year			5.56%	4.91%
Had Serious Thoughts of Suicide in Past Year			5.05%	4.58%
Had at Least One Major Depressive Episode in the Past Year	15.54%	15.08%	8.76%	7.51%

Table 10. Prevalence of Mental Illness (SAMHSA, 2020).

Behavioral health issues such as substance use disorders and mental illness often carry a stigma that prevents individuals from seeking help and others from providing help. Of those Missourians who experience serious psychological distress in the past year, an estimated 34 percent do not receive mental health treatment (SAMHSA, 2020). Research has shown that Mental Health First Aid, a public education program designed for the general public in appropriately responding to behavioral health issues, is associated with increased knowledge of behavioral health disorders, less stigmatization, and greater confidence to provide assistance (Kitchener, J.A., 2004; Kitchener, B.A. & Jorm, A.F., 2004). The Missouri Department of Mental Health partners with the National Council for Mental Wellbeing to implement Mental Health First Aid.. Missouri also offers Mental Health First Aid for Youth, for adults who work with young people.

School-Based Behavioral Health Education

	Missouri	United States
Past Month Illicit Drug Use	7.52%	8.37%
Past Month Binge Alcohol Use	5.02%	4.78%

Past Month Cigarette Use	3.41%	2.50%
Past Year Major Depressive Episode	15.54%	15.08%

Table 11. Behavioral Health Measures: Age 12 - 17 (SAMHSA, 2020).

An estimated 17.0 percent of Missouri's youth in grades 6 through 12 report using alcohol in the past 30 days. In addition, 8.9 percent and 15.5 percent reported using marijuana and electronic cigarettes, respectively, in the past month (Depue, S. & et al., 2020). Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) implements evidence-based programming to delay the onset of substance use and decrease the use of substances, improve overall school performance, and reduce incidents of violence. Age- and grade-appropriate curricula are taught. Screening and referral services are provided as needed. The program receives an annual evaluation by the Missouri Institute for Mental Health, University of Missouri-St. Louis.

Prescription Drug Overdose

Sub-state Planning Area	2019 Population	Opioid Deaths (2014-2018) Rates per 100,000 persons
Western	2,174,468	36.01
Eastern	2,299,721	126.06
Southwest	965,332	43.09
Southeast	697,907	36.82
State Total	6,137,428	70.96

Table 12. Rates of opioid deaths per 100,000 persons (DHSS, 2021).

In 2018, approximately one of every 56 deaths in Missouri is due to an opioid overdose and in St. Louis City the death rate due to opioid overdose was 50.19 per 100,000 residents (DHSS, 2021). An estimated 3.70 percent or 189,000 Missourians report nonmedical use of pain relievers in the past year. The percentage is comparable to that of the country as a whole (SAMHSA, 2020). In 2012, Missouri ranked 14th when comparing the rates of prescribing opioid pain relievers among states. Missouri had 94.5 opioid pain reliever prescriptions per 100 persons – compared to the rate of 82.5 for the United States (Paulozzi *et al*., 2014). Just a few months ago (June 2021), Missouri's Governor signed into law a bill which creates a statewide prescription drug monitoring program in the state of Missouri. Additionally, Missouri has received the opioid response grants through SAMHSA and strives to reduce the rate of opioid deaths.

Evidence-based Behavioral Health Practices

The Department of Mental Health (DMH) supports implementation of programs and practices that have proven effectiveness in reducing the impact of behavioral health disorders on individuals and families in Missouri. Missouri has implemented the following evidence-based practices in the treatment of serious mental illness (SMI):

- Integrated treatment for co-occurring mental illness and substance use disorders,
- Supported employment,
- Illness management and recovery,

- Assertive community treatment, and
- Consumer-operated services.

Individuals with co-occurring SMI and substance use disorders tend to have poorer outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers (McGovern, M.P., 2006). The evidence-based treatment model of care for persons with co-occurring disorders that is recommended by SAMHSA is the Integrated Treatment for Co-Occurring Disorders (ITCD). In the ITCD model, persons receive coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders. Missouri has 27 ITCD programs operating in 48 locations. Missouri has Medicaid approved billing codes for co-occurring individual counseling, group education, group counseling, and a supplemental individual assessment for substance use disorders. DMH monitors fidelity to the SAMHSA tool kit.

Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al*., 2008; Crowther, R.E. *et al*., 2001). Missouri has 32 supported employment programs. Providers contract with the Missouri Vocational Rehabilitation (VR) to offer supported employment services to ensure that:

- Eligibility is based on consumer choice;
- Supported employment is integrated with treatment;
- Competitive employment is the goal;
- Job search starts soon after the consumer expresses interest in working;
- Follow-along supports are continuous; and
- Consumer preferences are recognized.

Fidelity is monitored for the Individualized Placement Support (IPS) Supported Employment model.

Illness management recovery strategies have been shown to increase the individual's knowledge of their condition, aid in medication compliance, and reduce the occurrence and severity of symptom relapse (Mueser, K.T. *et al*., 2002). DMH, in collaboration with the State Medicaid authority, has established an enhanced rate for Psychosocial Rehabilitation. Twenty community mental health centers provide these services that focus on health, wellness, and recovery. Fidelity to this evidence-based practice is not monitored.

Assertive Community Treatment (ACT) has been shown to reduce hospitalizations for individuals with severe mental illness (Phillips, S.D. *et al*., 2001). In Missouri, ACT services are made available to adults with serious and persistent mental illness who: 1) are high users of inpatient beds, 2) may have a co-occurring substance use disorder, 3) have involvement with the criminal justice system, and 4) are homeless. DMH funds nine adult ACT programs and ten ACT

Transitional Aged Youth (TAY) programs. Missouri continues to monitor fidelity of new program implementation as well as on-going services.

Research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program (COSP) Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers *et al*., 2007). DMH funds four COSP programs.

In addition to the evidence-based practices listed above, DMH also funds Dialectical Behavior Therapy (DBT), a cognitive-behavioral treatment initially developed to treat individuals with borderline personality disorder (BPD) but has also been found to be effective for persons with other diagnoses. Several studies have shown that DBT had better outcomes in the treatment of BPD compared to treatment as usual on measures of anger, parasuicidality, and mental health (Stoffers, J.M. *et al*., 2012). Introductory and advanced DBT training has been made available statewide. DMH has partnered with the University of Missouri Psychiatric Center to produce an online training in communication strategies. DMH also supports a DBT website (www.dbtmo.org) to provide information on DBT and the DBT certification process.

Substance Use-Related Services for Persons who Inject Drugs

Sub-state Planning Area	2019 Population Age 20+	Estimated PWID Need	PWID FY 2020 Served	Estimated PWID Need but Not Receive	Penetration Gap
Western	1,621,495	7,783	3,616	4,167	53.54%
Eastern	1,740,370	10,790	4,716	6,074	56.29%
Southwest	722,896	3,470	2,542	928	26.74%
Southeast	525,376	2,522	227	2,295	91.00%
State Total	4,610,137	24,434	12,901	11,533	47.20%

Table 13. Estimates of prevalence and need for the treatment of injection drug use.

In the past, the number of persons who inject drugs (PWID) was estimated at 0.19 percent of the population aged 12 or older from NSDUH national-level data. Based on 1) the number of PWID served and the number on wait lists and given that 2) NSDUH excludes some populations with higher rates of drug use such as incarcerated individuals, homeless, hospitalized patients, and college dormitory students, the NSDUH estimate was believed to generate estimates for Missouri that seriously underestimates the number of persons who inject drugs in the state. Research from Brady *et al*. estimated the prevalence of PWID in the U.S. and in 76 metropolitan statistical areas (MSA) (Brady, J.E. *et al*., 2008). Brady's estimates for persons who inject drugs in the Kansas

City and St. Louis MSA's exceeded that generated from the NSDUH data by a factor of 2.7 and 3.4, respectively. Brady's prevalence rate for Kansas City MSA and St. Louis MSA was applied to the populations of Northwest and Eastern regions. The remaining regions were assumed to have a similar rate as that of Northwest region and a corresponding estimate was generated for the remaining regions. The number of PWID's served by sub-state region was obtained from the publicly-funded system (Missouri Department of Mental Health, 2019). The estimated number for unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not receive treatment. In Missouri, methamphetamine injection drug use is prevalent throughout the rural areas of the state but is particularly notable in Southwest, Southeast, and Northwest Regions. Heroin and other Opioid injection drug use are highly concentrated in Eastern Region impacting both urban and rural locations. The Eastern Region accounted for 67 percent of the state's heroin-related deaths between 2014 and 2018 (Missouri Department of Health and Senior Services, 2021).

Substance Use-Related Services for Pregnant Women and Women with Dependent Children

An estimated 8.5 percent of pregnant women have a substance use disorder. In general, an estimated 5.5 percent of women have a substance use disorder (SAMHSA, 2020).

Sub-state Planning Area	2019 Female Population Age 12+	Women Need (5.5%)	Women FY 2020 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	940,187	51,710	5,856	45,854	88.68%
Eastern	1,023,178	56,275	5,686	50,589	89.90%
Southwest	421,445	23,179	3,444	19,735	85.14%
Southeast	299,896	16,494	2,623	13,871	84.10%
State Total	2,684,706	147,659	17,609	130,050	88.07%

Table 14. Prevalence of substance use problems among women (SAMHSA, 2020).

County-level population of females age 12 or older was obtained from the Missouri Census Data Center and aggregated to the sub-state areas (Missouri Census Data Center, 2019). The estimated percent in need of treatment (5.5%) is obtained from the SAMHSA Behavioral Health Barometer report (SAMHSA, 2020). The number served in the state system in FY 2020 was obtained from the Department of Mental Health information system. The difference between estimated need and number served is a combination of number served outside of the state system and unmet need.

Mental Health Services for Transition-Aged Youth and Young Adults

Sub-state Planning Area	2019 Population 16-17	2019 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (6.85%)	Total Estimated Need
Western	55,003	243,445	3,850	22,129	25,979
Eastern	57,525	225,072	4,027	20,459	24,486
Southwest	24,599	106,495	1,722	9,680	11,402
Southeast	17,844	68,984	1,249	6,271	7,520
State Total	154,971	643,996	10,848	58,539	69,387

Table 15. Estimated need for mental health services among transition age youth and young adults.

Individuals who are transitioning into adulthood and have or develop a serious mental illness face unique challenges. Compared to the general population, these individuals tend to have increased difficulty in reaching developmental milestones such as graduating from high school, gaining employment, securing stable housing, and developing and sustaining meaningful relationships. In a study by the U.S. Government Accounting Office (GAO) (2008), young adults age 18 to 26 with SMI graduated from high school at a lower rate compared to those without SMI (64% vs. 83%). For young adults who were receiving disability payments from SSI or DI, the high school graduation rate was even lower at 52%. Transition-age youth are more likely to become involved with the juvenile justice system and are at increased risk for substance use (Gilmer, T. P. *et al*., 2012). Although SMI may develop earlier than age 16, it is not uncommon for the diagnosis to be made during the late teens and early twenties. As such, individuals and their families may be inexperienced at navigating multiple systems of care and programs. Adult and youth programs often have differing eligibility requirements and service mix that can cause disruptions in continuity of care once an individual reaches age 18. In looking at mental health service utilization in the U.S., Pottick *et al*. (2008) found that service utilization fell by almost 50 percent at the age of emancipation. Adult programs may be more tailored to the needs of older adults which may cause young adults to feel disenfranchised and result in treatment drop-out (GAO, 2008). In FY 2021, DMH provided community-based mental health services to 12,451 transition-aged youth and young adults.

Behavioral Healthcare Services for Children

Sub-state Planning Area	2019 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2020	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	493,562	34,550	6,370	28,180	81.56%

Sub-state Planning Area	2019 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2020	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Eastern	504,478	35,314	6,000	29,314	83.01%
Southwest	217,001	15,191	4,687	10,504	69.15%
Southeast	155,544	10,889	3,269	7,620	69.98%
State Total	1,370,585	95,941	19,573	76,368	79.60%

Table 16. FY 2020 Estimated prevalence of childhood serious emotional disturbance.

Sub-state Planning Area	2019 Population Age 12-17	Estimated Need 4.04%	Received Treatment FY 2020	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Western	167,268	6,758	674	6,084	90.03%
Eastern	172,908	6,985	666	6,319	90.47%
Southwest	74,558	3,012	502	2,510	83.33%
Southeast	54,138	2,187	264	1,923	87.93%
State Total	468,872	18,942	2,106	16,836	88.88%

Table 17. FY 2018 Estimated prevalence of adolescent substance use disorder.

Children with behavioral health issues face challenges in many aspects of their daily lives. Missouri supports the systems of care approach that recognizes the importance of family, school, and community and in which services are provided through a comprehensive, seamless system. Both substance use disorder and mental health services for children are coordinated under the Department of Mental Health (DMH) Children's Director. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances. The Comprehensive Substance Treatment and Rehabilitation (CSTAR) Adolescent program offers a full continuum of services for youth age 12 to 17 with substance use disorders.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Coordination of Primary Care and Behavioral Health Services

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Coordinate consumers' primary and behavioral healthcare in order to improve health and reduce medical costs.

Strategies to attain the goal:

1) Continue to coordinate preventative and primary care for Health Home participants
2) Continue outreach to Medicaid-enrolled adults who have a substance use disorder and/or serious mental illness, have high annual healthcare costs, and are not currently enrolled in behavioral health treatment
3) contract with the Missouri Institute for Mental Health for ongoing evaluation of Missouri's Health Home Programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of participants in Health Homes per fiscal year

Baseline Measurement: 31,976

First-year target/outcome measurement: 31,500

Second-year target/outcome measurement: 31,500

Data Source:

Missouri Medicaid Data

Description of Data:

The number of Health Home participants is determined from a Per Member Per Month (PMPM) data file submitted to DMH from the Missouri Medicaid agency, MO HealthNet, on a monthly basis. These are individuals who participated at any time during the specified fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of participants in DM 3700 per fiscal year

Baseline Measurement: 6,911

First-year target/outcome measurement: 5,700

Second-year target/outcome measurement: 5,700

Data Source:

DMH information system

Description of Data:

A participant in DM 3700 is defined as a consumer who is listed on the master list of DM 3700 participants and has an open episode of care for behavioral health services, including mental health or substance use, during the specified fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of participants in SUD Disease Management per fiscal year

Baseline Measurement: 2,345

First-year target/outcome measurement: 1,800

Second-year target/outcome measurement: 1,800

Data Source:

DMH information system

Description of Data:

A participant in SUD Disease Management (SUD DM) is defined as a consumer who is listed on the master list of SUD DM participants and has an open episode of care for behavioral health services, including mental health or substance use, during the specified fiscal year.

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Crisis Intervention

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Promote safety and emotional stability, minimize further deterioration of mental state, increase access to treatment and support services, and improve individual outcomes for individuals in behavioral health crisis; better utilize limited criminal justice and healthcare resources by linking individuals in need of behavioral healthcare services with those services.

Strategies to attain the goal:

1) Identify and address structural barriers, miscommunications, and consistent patterns that reduce access to behavioral healthcare services.
2) Provide behavioral health expertise to law enforcement, court personnel, and primary healthcare staff in order to more effectively respond to behavioral health crises.
3)Advocate for and engage individuals in crisis in behavioral health treatment and support services.
4) Provide immediate person-centered interventions to individuals in behavioral health crisis and facilitate timely access to services and supports.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of referrals to CBHLs per fiscal year

Baseline Measurement: 10,472

First-year target/outcome measurement: 15,000

Second-year target/outcome measurement: 20,000

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

Number of Community Behavioral Health Liaison contacts are tracked by the MBHC

Data issues/caveats that affect outcome measures:

An individual may account for more than one contact during the fiscal year.

Indicator #: 2

Indicator: Number served in ERE project per fiscal year

Baseline Measurement: 2,029

First-year target/outcome measurement: 1,900

Second-year target/outcome measurement: 2,000

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

Number of persons served in the Emergency Room Enhancement (ERE) project is tracked and reported by the MBHC.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of law enforcement officers trained in CIT per fiscal year

Baseline Measurement: 1,217

First-year target/outcome measurement: at least 900

Second-year target/outcome measurement: at least 900

Data Source:

Missouri Behavioral Health Council (MBHC)

Description of Data:

Number of officers trained in CIT is tracked and reported by the MBHC.

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Implementation of 988

Baseline Measurement: NA

First-year target/outcome measurement: In Process

Second-year target/outcome measurement: Complete

Data Source:

DBH Prevention and Crisis Unit

Description of Data:

The implementation of 988 is being monitored by the DBH Prevention and Crisis Services staff

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Department of Corrections Community Supervised Offenders

Priority Type: SAT, MHS

Population(s): SMI, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Improve access to clinically appropriate services

Strategies to attain the goal:

1) Monitor and target technical assistance to Probation and Parole Officers and treatment providers on the prioritization process for offenders in need of substance use disorder (SUD) treatment in order to facilitate rapid assessment and treatment initiation.
2) Maintain Memorandum of Understandings (MOU) with the Department of Corrections for coordination of behavioral health treatment services.
3) Continue the Community Mental Health Treatment (CMHT) and Offenders with Serious Mental Illness (OSMI) programs.
4) Continue to participate on the DOC Oversight Committee.
5) Coordinate with Department of Corrections (DOC) to administrate the Improving Community Treatment Success (ICTS) program with a focus on reducing the risk of harm due to substance use and mental health conditions, reducing recidivism, improving opportunities for employment or education, and improving the availability of stable housing.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Current MOUs between DMH and DOC

Baseline Measurement: Yes

First-year target/outcome measurement: Yes

Second-year target/outcome measurement: Yes

Data Source:

DMH Contracts Unit

Description of Data:

MOUs are maintained by the DMH Contracts Unit.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of Oversight Committee Meetings

Baseline Measurement: 13

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 6

Data Source:

The Division of Behavioral Health's (DBH) Criminal Justice Services Manager is the organizer of these meetings.

Description of Data:

Oversight meetings are scheduled by DBH Criminal Services Manager.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of consumers served in the ICTS program

Baseline Measurement: 548

First-year target/outcome measurement: 700

Second-year target/outcome measurement: 700

Data Source:

DMH information system

Description of Data:

The number of consumers served in the ICTS program is tracked in the DMH information system.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Tobacco Prevention

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Reduce tobacco initiation and promote tobacco cessation among vulnerable populations

Strategies to attain the goal:

1) Support provider training in tobacco cessation with proven effectiveness.
2) Promote the inclusion of tobacco cessation in the consumer's behavioral treatment plan.
3) Support tobacco cessation in Missouri's college campuses.
4) Ensure the provision of tobacco enforcement and merchant education:
a. Continue contracting with the Food and Drug Administration for the enforcement of federal tobacco control laws.
b. Maintain a Memorandum of Understanding with the Division of Alcohol and Tobacco Control for state and federal enforcement of tobacco control laws.
c. Conduct a merchant education visit to every tobacco retailer in the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Synar non-compliance rate is less than 20 percent

Baseline Measurement: Yes

First-year target/outcome measurement: Yes

Second-year target/outcome measurement: Yes

Data Source:

Annual Synar Report

Description of Data:

Synar non-compliance rate is determined from the Annual Synar Survey. For FY2022, the Annual Synar Survey will be completed by October 1, 2022. For the FY 2023, the Annual Synar Survey will be completed by October 1, 2023.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of tobacco retailers visited and provided with retailer education materials per fiscal year

Baseline Measurement: 5,456

First-year target/outcome measurement: 4,800

Second-year target/outcome measurement: 4,800

Data Source:

DMH Database

Description of Data:

Number of tobacco retailers visited and provided education materials is documented by prevention agencies, entered into a database by DMH staff and reported in the State's Annual Synar Report.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of Tobacco Treatment Specialists per fiscal year

Baseline Measurement: 25

First-year target/outcome measurement: at least 25

Second-year target/outcome measurement: at least 25

Data Source:

Division of Behavioral Health Prevention Unit

Description of Data:

Number of Tobacco Treatment Specialists is tracked by the Prevention Unit staff.

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Recovery Support Services

Priority Type: SAT, MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Rural, Criminal/Juvenile Justice, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Provide support services to promote sustained recovery from behavioral health disorders.

Strategies to attain the goal:

1) Continue to grow the number of Certified Peer Specialists working in Missouri's behavioral health treatment and recovery system of care.
2) Continue the four Drop-In Centers for persons with mental illness.
3) Promote the use of IPS Supported Employment.
4) Promote the use of Family Support and Youth Peer Support.
5) Promote the use of Recovery Support Services.
6) Maintain a housing unit to administer the Continuum of Care (CoC) grants to provide housing assistance to the chronically homeless.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Certified Peer Specialists

Baseline Measurement: 1,003

First-year target/outcome measurement: 850

Second-year target/outcome measurement: 850

Data Source:

Division of Behavioral Health (DBH) Recovery Services Unit

Description of Data:

The number of Certified Peer Specialists is tracked by the DBH Recovery Services Unit

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of contracts for Consumer Operated Services Programs for persons with mental illness per fiscal year

Baseline Measurement: 4

First-year target/outcome measurement: 4

Second-year target/outcome measurement: 4

Data Source:

DMH Contracts Unit

Description of Data:

Contracts are maintained by the DMH Contracts Unit

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of IPS Supported Employment programs per fiscal year

Baseline Measurement: 26

First-year target/outcome measurement: 26

Second-year target/outcome measurement: 26

Data Source:

DBH Recovery Services Unit

Description of Data:

The number of IPS Supported Employment programs is tracked by DBH Recovery Services Unit staff.

Data issues/caveats that affect outcome measures:

Funding for IPS Supported Employment programs is though Vocational Rehabilitation budget rather than DMH budget. A reduction or withholding of VR budget items could result in a reduction of these programs.

Indicator #: 4

Indicator: Number of Youth Peer Support Specialists

Baseline Measurement: 12

First-year target/outcome measurement: at least 15

Second-year target/outcome measurement: at least 15

Data Source:

DBH Recovery Services Unit

Description of Data:

The number of Youth Peer Support Specialists are tracked by the DBH Recovery Services Unit staff.

Data issues/caveats that affect outcome measures:

None

Indicator #: 5

Indicator: Number of Recovery Support Providers

Baseline Measurement: 53

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

DMH Contracts Unit

Description of Data:

Contracts are maintained by the DMH Contracts Unit

Data issues/caveats that affect outcome measures:

None

Priority #: 6

Priority Area: Medication Assisted Treatment for Substance Use Disorders

Priority Type: SAT

Population(s): PWWDC, PWID, Other (Rural, Criminal/Juvenile Justice, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

To further integrate medication therapy into the substance use disorder treatment service delivery system.

Strategies to attain the goal:

1) Monitor utilization of Medication Assisted Treatment (MAT) by provider and provide technical assistance as needed.
2) Increase utilization of different medications used in MAT at a given treatment provider.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consumers receiving medication therapy per fiscal year

Baseline Measurement: 7,541

First-year target/outcome measurement: 6,500

Second-year target/outcome measurement: 6,500

Data Source:

DMH information system and Medicaid claims

Description of Data:

Number of consumers receiving medication assisted treatment including use of methadone, Vivitrol, naltrexone, buprenorphine-containing medications, Antabuse and acamprosate (and any future FDA-approved MAT medications) is determined from billing outside of Detoxification services.

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: Community Advocacy and Education

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Create positive community norms, policy change, promote mental wellness, and reduce alcohol, tobacco and other drug availability in Missouri's communities.

Strategies to attain the goal:

1) Build state and community capacity for fostering strong partnerships and identifying new opportunities for collaboration.
2) Further data capacity in support of data-driven strategic planning to include the continuation of the Missouri Student Survey and the Behavioral Health web too.
3) Fund evidence-based programming to prevent substance use and bullying among high-risk youth.
4) Continue the education initiative in Eastern Missouri to address heroin and other opioid drug use.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained in suicide prevention and intervention per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 1,500

Second-year target/outcome measurement: 2,000

Data Source:

DBH contracted providers

Description of Data:

The number of individuals trained in suicide prevention and intervention is tracked and reported by contracted providers.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of high-risk youth served in prevention programs per fiscal year

Baseline Measurement: 2,960

First-year target/outcome measurement: at least 3,000

Second-year target/outcome measurement: at least 3,000

Data Source:

DBH contracted providers

Description of Data:

Number of high-risk youth served in prevention programs is tracked and reported by contracted providers.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of persons trained in Mental Health First Aid per fiscal year

Baseline Measurement: 6,600

First-year target/outcome measurement: at least 6,500

Second-year target/outcome measurement: at least 6,500

Data Source:

DBH Prevention Unit

Description of Data:

Number trained in Mental Health First Aid (MHFA) is tracked by DBH Prevention Unit staff.

Data issues/caveats that affect outcome measures:

None

Priority #: 8

Priority Area: School-based Prevention Education

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

To delay onset of substance use, reduce use, improve overall school performance, and reduce incidents of violence.

Strategies to attain the goal:

1) Enhance protective factors and reverse or reduce risk factors for substance use and violence.
2) Improve academic and social-emotional learning to address risk factors.
3) Employ interactive techniques that allow for active involvement in learning.
4) Reinforce prevention skills over time with repeated interventions.
5) Ensure programming is culturally competent and age appropriate.
6) Conduct annual fidelity reviews.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of students participating in SPIRIT per fiscal year

Baseline Measurement: 9,834

First-year target/outcome measurement: at least 8,000

Second-year target/outcome measurement: at least 8,000

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

SPIRIT participation is tracked and reported by the program evaluator, MIMH.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Annual report generated

Baseline Measurement: Yes

First-year target/outcome measurement: Yes

Second-year target/outcome measurement: Yes

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

Annual report is generated and provided to DMH by MIMH. DMH posts the annual report to the DMH public website.

Data issues/caveats that affect outcome measures:

None

Priority #: 9

Priority Area: Prescription Drug Overdose Deaths

Priority Type: SAP

Population(s): PWWDC, PWID, Other (Rural, Criminal/Juvenile Justice, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Prevention Opioid-related deaths and connect individuals experiencing overdose events to substance use disorder treatment.

Strategies to attain the goal:

1) Increase the number of first responders, medical professionals, and other eligible groups are trained to carry and administer naloxone.
2) increase public awareness of opioid risks and best practices for assisting during an overdose event.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained to carry and administer naloxone per fiscal year

Baseline Measurement: 6,228

First-year target/outcome measurement: 4,000

Second-year target/outcome measurement: 4,000

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

The number of individuals trained to carry and administer naloxone is tracked and reported by MIMH

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of naloxone kits distributed per fiscal year

Baseline Measurement: 30,462

First-year target/outcome measurement: 6,000

Second-year target/outcome measurement: 6,000

Data Source:

Missouri Institute for Mental Health (MIMH)

Description of Data:

The number of naloxone kits distributed is tracked and reported by MIMH.

Data issues/caveats that affect outcome measures:

None

Priority #: 10

Priority Area: Evidence-based Behavioral Health Practices

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC

Goal of the priority area:

Continue evidence-based practice to the same standards and fidelity as shown to be effective in research

Strategies to attain the goal:

1) Continue to support EBP programs.
2) Provide ongoing monitoring of Fidelity in EBP programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults served in ITCD per fiscal year

Baseline Measurement: 3,604

First-year target/outcome measurement: at least 3,000

Second-year target/outcome measurement: at least 3,000

Data Source:

DMH information system

Description of Data:

The number of ITCD consumers is determined from paid encounters for ITCD services.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of adults served in ACT per fiscal year

Baseline Measurement: 829

First-year target/outcome measurement: at least 900

Second-year target/outcome measurement: at least 900

Data Source:

DMH information system

Description of Data:

The number of adults served in the Assertive Community Treatment (ACT) program is determined from paid encounters for ACT services.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of women served by Women & Children specialty teams per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

DMH contracted providers

Description of Data:

The number of women serviced by Women & Children specialty teams is tracked and reported by contracted providers.

Data issues/caveats that affect outcome measures:

Women who were transferred between specialty teams may be counted more than once.

Priority #: 11

Priority Area: Persons who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Ensure the provision of services to persons who inject drugs in accordance with SABG statutory requirements.

Strategies to attain the goal:

1) Monitor contractual requirements pertaining to PWID
2) Generate reports to monitor length of time to initiate treatment and percent engagement in treatment
3) Increase one-on-one discussions with key provider staff about data reports and target technical assistance as needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of persons who inject drugs served in substance use disorder treatment per fiscal year

Baseline Measurement: 12,830

First-year target/outcome measurement: 10,000

Second-year target/outcome measurement: 10,000

Data Source:

DMH information system

Description of Data:

The number of persons who inject drugs is determined from the route of administration for any of the substances reported in the TEDS data and paid encounters for substance use disorder treatment captured in the DMH information system during the fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Average number of days from initial contact to the first service paid for PWID per fiscal year

Baseline Measurement: 4.91

First-year target/outcome measurement: 6 or less

Second-year target/outcome measurement: 6 or less

Data Source:

DMH information system

Description of Data:

The average number of calendar days between the initial contact date to the date of service of the first paid encounter PWID as reported at the treatment admission per fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Percent of persons who inject drugs who have engaged in treatment per fiscal year

Baseline Measurement: 85%

First-year target/outcome measurement: at least 80%

Second-year target/outcome measurement: at least 80%

Data Source:

DMH information system

Description of Data:

The percent of the persons who inject drugs as reported at the treatment admission that had at least 3 paid encounters during the program per fiscal year.

Data issues/caveats that affect outcome measures:

None

Priority #: 12

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Continue to provide services to pregnant women and women with dependent children

Strategies to attain the goal:

1) Monitor contractual compliance with regard to prioritization of admission for pregnant women to substance use disorder treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children served in substance use disorder treatment per fiscal year

Baseline Measurement: 6,497

First-year target/outcome measurement: 6,000

Second-year target/outcome measurement: 6,000

Data Source:

DMH information system

Description of Data:

The number of pregnant women and women with dependent children served is capture in the DMH information system as individuals with a paid encounter for substance use disorder services and indicate pregnant during treatment, having dependent children or both.

Data issues/caveats that affect outcome measures:

None

Priority #: 13

Priority Area: Mental Health Services for Transition Aged Youth and Young Adults

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Promote collaboration, implementation of effective interventions and supports, and enhance skills of individuals who work with transition aged youth, young adults and their families with behavioral health needs including those that may be at risk of a First Episode Psychosis (FEP).

Strategies to attain the goal:

1) Continue to participate in the Oversight Advisory Group which focuses on the needs of youth and young adults with behavioral health issues including being at risk of or experiencing FEP.
2) Provide education on the importance of advocacy, prevention, early identification/intervention and evidence-based treatment
3) Provide training on evidence-based and promising practices
4) Expand Integrated Treatment for Co-Occurring Disorders (ITCD) services to meet the unique needs of the transition aged youth/ young adult population
5) Promote ACT TAY programs statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of education sessions per fiscal year

Baseline Measurement: 11

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 6

Data Source:

DBH Children's Unit

Description of Data:

The number of education sessions are tracked by the DMH Children's Unit.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of evidence-based practice related provider trainings per fiscal year

Baseline Measurement: 8

First-year target/outcome measurement: 8

Second-year target/outcome measurement: 8

Data Source:

DMH Children's Unit

Description of Data:

The number of trainings related to evidence-based practices for transition aged youth and young adults is tracked and reported by the DMH Children's Unit staff.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of Transition Aged Youth and Young Adults served in ITCD per fiscal year

Baseline Measurement: 362

First-year target/outcome measurement: at least 300

Second-year target/outcome measurement: at least 300

Data Source:

DMH information system

Description of Data:

The number of transition aged youth and young adults served in ITCD is captured in the paid encounters for mental health services in the DMH information system.

Data issues/caveats that affect outcome measures:

None

Indicator #: 4

Indicator: Number of consumers served in ACT TAY programs per fiscal year

Baseline Measurement: 549

First-year target/outcome measurement: at least 500

Second-year target/outcome measurement: at least 500

Data Source:

DMH information system

Description of Data:

The number of consumers with paid encounters in the Youth Assertive Community Treatment program is captured in the DMH information system.

Data issues/caveats that affect outcome measures:

None

Priority #: 14

Priority Area: Behavioral Healthcare Services for Children

Priority Type: SAT, MHS

Population(s): SED, Other (Adolescents w/SA and/or MH)

Goal of the priority area:

To enhance children's behavioral health services by increasing knowledge of effective services, supports and interventions, enhancing the skills of service providers and expanding services based on the needs of the children, youth and families served.

Strategies to attain the goal:

1) Continue the statewide Children's Committee with standing agenda items for CSTAR or SUD treatment items. Committee will provide collaboration regarding issues of policy, training, treatment, funding, and outreach for adolescent substance use disorders.
2) Increase dissemination of research, best practices and success stories.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of meetings with adolescent substance use focus

Baseline Measurement: 3

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 3

Data Source:

DMH Children's Unit

Description of Data:

The number of meetings is tracked by the DMH Children's Unit staff

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of posts of articles, research, and stories specific to behavioral healthcare for children per fiscal year

Baseline Measurement: 23

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 20

Data Source:

DMH Children's Unit

Description of Data:

The number of postings is tracked and reported by the DMH Children's Unit staff.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of adolescents served in substance use disorder treatment

Baseline Measurement: 2,119

First-year target/outcome measurement: 1,800

Second-year target/outcome measurement: 1,800

Data Source:

DMH information system

Description of Data:

The number of adolescents served in substance use disorder treatment is captured in the paid encounters in the DMH information system.

Data issues/caveats that affect outcome measures:

None

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$19,913,155.00		$130,722,568.00	$23,869,689.00	$85,514,814.00	$0.00	$0.00		$19,907,181.00	$8,596,037.00
a. Pregnant Women and Women with Dependent Children[c]	$2,254,999.00		$2,492,246.00	$0.00	$8,608,408.00	$0.00	$0.00		$536,450.00	$670,563.00
b. All Other	$17,658,156.00		$128,230,322.00	$23,869,689.00	$76,906,406.00	$0.00	$0.00		$19,370,731.00	$7,925,474.00
2. Primary Prevention[d]	$5,310,200.00		$0.00	$11,438,917.00	$2,907,264.00	$0.00	$0.00		$4,976,920.00	$2,149,370.00
a. Substance Abuse Primary Prevention	$5,310,200.00		$0.00	$11,438,917.00	$2,907,264.00	$0.00	$0.00		$4,976,920.00	$2,149,370.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$95.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
5. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$1,327,549.00		$0.00	$3,513,596.00	$2,242,368.00	$0.00	$0.00		$0.00	$0.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$26,550,999.00**	**$0.00**	**$130,722,568.00**	**$38,822,202.00**	**$90,664,446.00**	**$0.00**	**$0.00**	**$0.00**	**$24,884,101.00**	**$10,745,407.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2022

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]		$0.00	$0.00	$877,088.00	$770,876.00	$0.00	$0.00	$0.00		$833,593.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$1,210,697.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,400,000.00		$1,698,575.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$0.00	$4,436,189.00	$187,287,579.00	$0.00	$0.00	$0.00		$0.00
7. Other 24-Hour Care		$0.00	$0.00	$837,718.00	$8,249,368.00	$0.00	$0.00	$0.00		$0.00
8. Ambulatory/Community Non-24 Hour Care		$9,685,572.00	$428,184,190.00	$14,347,906.00	$76,275,755.00	$0.00	$0.00	$8,866,337.00		$4,949,023.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$605,349.00	$0.00	$522,995.00	$1,021,292.00	$0.00	$0.00	$0.00		$0.00
10. Crisis Services (5 percent set-aside)[g]		$605,349.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,647,500.00		$2,291,365.00
11. Total	**$0.00**	**$12,106,967.00**	**$428,184,190.00**	**$21,021,896.00**	**$273,604,870.00**	**$0.00**	**$0.00**	**$13,913,837.00**	**$0.00**	**$9,772,556.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	7,300	720
2. Women with Dependent Children	38,000	4,884
3. Individuals with a co-occurring M/SUD	181,000	20,678
4. Persons who inject drugs	24,434	12,901
5. Persons experiencing homelessness	1,120	4,140

Please provide an explanation for any data cells for which the state does not have a data source.
Estimates for number in need for 1) pregnant women, 2) women with dependent children , and 3) individuals with a co-occurring M/SUD (any mental illness) are based on estimates from the National Survey on Drug Use and Health (2018-2020). Estimated number in need for persons who inject drugs are based on prevalence estimates from Brady et al. (2008) (https://www.ncbi.nlm.nih.gov/pubmed/18344002). Estimated number in need for persons experiencing homelessness (point-in-time) are from the Housing and Urban Development (HUD) 2020 Continuum of Care Homeless Assistance Programs (https://files.hudexchange.info/reports/published/CoC_PopSub_State_MO_2020.pdf). Number in treatment for all cohorts reflect the number served by the Missouri Department of Mental Health in SFY 2020.
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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$19,913,155.00	$19,907,181.00	$8,596,037.00
2 . Primary Substance Use Disorder Prevention	$5,310,200.00	$4,976,920.00	$2,149,370.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$95.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$1,327,549.00	$0.00	$0.00
6. Total	**$26,550,999.00**	**$24,884,101.00**	**$10,745,407.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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FFY 2021 SA Block Award: Amount of primary prevention funds planned for primary prevention programs (this amount should match the total reported in Table 5a and Table 5b) $4,454,925
Amount of primary prevention funds in Table 4, Line 2 that are planned for Prevention-SA resource development (this amount should not include funds reported in Table 5a or Table 5b) $855,275

ARP Award: Amount of primary prevention funds planned for primary prevention programs (this amount should match the total reported in Table 5a and Table 5b) $2,108,120. Amount of primary prevention funds in Table 4, Line 2 that are planned for Prevention-SA resource development (this amount should not include funds reported in Table 5a or Table 5b) $41,250

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	**IOM Target**	**FFY 2022**		
		SA Block Grant Award	**COVID-19[1]**	**ARP[2]**
1. Information Dissemination	Universal	$294,147	$300,000	$0
	Selective	$51,797	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$345,944**	**$300,000**	**$0**
2. Education	Universal	$613,009	$250,000	$75,000
	Selective	$1,104,791	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$1,717,800**	**$250,000**	**$75,000**
3. Alternatives	Universal	$10,291	$0	$0
	Selective	$398,960	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$409,251**	**$0**	**$0**
4. Problem Identification and Referral	Universal	$1,491	$0	$0
	Selective	$575	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$2,066**	**$0**	**$0**
	Universal	$1,391,536	$4,426,920	$2,033,120

5. Community-Based Process	Selective	$371,013	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$1,762,549**	**$4,426,920**	**$2,033,120**
6. Environmental	Universal	$15,054	$0	$0
	Selective	$7,398	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$22,452**	**$0**	**$0**
7. Section 1926 Tobacco	Universal	$0	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$106,218	$0	$0
	Selective	$88,645	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$194,863**	**$0**	**$0**
Total Prevention Expenditures		**$4,454,925**	**$4,976,920**	**$2,108,120**
Total SABG Award[3]		**$26,550,999**	**$24,884,101**	**$10,745,407**
Planned Primary Prevention Percentage		**43.46 %**	**46.37 %**	**107.39 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$2,134,800	$4,676,920	$2,108,120
Universal Indirect	$296,946	$300,000	$0
Selective	$2,023,179	$0	$0
Indicated	$0	$0	$0
Column Total	**$4,454,925**	**$4,976,920**	**$2,108,120**
Total SABG Award[3]	**$26,550,999**	**$24,884,101**	**$10,745,407**
Planned Primary Prevention Percentage	**16.78 %**	**20.00 %**	**19.62 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☑	☑	☐
Military Families	☐	☐	☐
LGBTQ	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☑	☑	☑
Hispanic	☐	☐	☐
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$0.00	$0.00	$0.00	$0.00	$41,250.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$9,361.00	$805,275.00	$0.00	$0.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$50,000.00	$0.00	$0.00	$0.00
8. Total	**$9,361.00**	**$855,275.00**	**$0.00**	**$0.00**	**$41,250.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2023

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$0.00	$692,500.00	$148,000.00	$0.00	$0.00	$148,000.00
2. Infrastructure Support	$0.00	$291,131.00	$0.00	$0.00	$174,679.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$1,005,535.00	$0.00	$0.00	$1,508,302.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7. Training and Education	$294,472.00	$98,000.00	$146,250.00	$294,472.00	$72,000.00	$164,250.00
8. Total	**$294,472.00**	**$2,087,166.00**	**$294,250.00**	**$294,472.00**	**$1,754,981.00**	**$312,250.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Health Homes: The Health Home under the Affordable Care Act is an alternative approach to the delivery of health care services and better health outcomes than traditional care. The Health Home has many characteristics of the Patient Centered Medical Home but is customized to meet the specific needs of adults with serious mental illness and youth with serious emotional disturbance who often have other co-occurring chronic medical illnesses. Missouri's initiative enhances the existing psychiatric rehabilitation program by adding nurse care managers and a primary care physician consultant to each Community Mental Health Center (CMHC). Additionally, it gives the enhanced psychiatric rehabilitation team access to a wealth of care management reports designed to help them both identify treatment gaps and to assist individuals in developing healthy lifestyles and managing their chronic illnesses. Goals of the CMHC Health Home initiative are to reduce unnecessary hospitalization and emergency room visits, while improving the health status of the individuals enrolled in the program. Missouri's plan was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2011. Implementation began in January 2012. Under Missouri's plan, 26 CMHCs are contracted as Health Home providers. For an individual to be eligible for enrollment in Missouri's Health Home, they must meet one of the following three conditions: 1) have a serious and persistent mental illness, 2) have a mental health condition and a substance use disorder, or 3) have a mental health condition or a substance use disorder and one other chronic health condition. In FY 2014, Missouri began piloting a Children's Health Home program targeting children with co-occurring serious emotional disturbance and obesity. In FY 2019, Missouri began developing State Plan Amendment (SPA) language to include complex trauma as a qualifying chronic condition.

Disease Management 3700 (DM 3700) & SUD Disease Management (SUD DM): The Disease Management programs are a result of collaboration between the Department of Mental Health (DMH) and the Missouri Medicaid agency, MO HealthNet. DM 3700 was implemented in November 2010 and targets Medicaid-enrolled adults with a serious mental illness and high Medicaid costs who are currently not engaged in services at a DMH-contracted agency. The SUD DM project was implemented in February 2014 as ADA DM, in August 2020 in an effort to stay current with best practices and use the most appropriate language ADA DM was renamed Substance Use Disorder (SUD) DM. SUD DM targets Medicaid-enrolled adults with substance use disorders and high Medicaid costs who are not currently engaged in at a DMH-contracted agency. DMH funds outreach efforts and MO HealthNet funds behavioral health treatment for those enrolled in the program. Health Home providers also participate in the DM 3700 program. Seventeen CSTAR providers (i.e. Missouri's only Medicaid reimbursable substance use disorder program) participate in the SUD DM project. Each provider added a nurse liaison to assist with care coordination of complex physical health conditions of program participants .DMH and community partners meet regularly to discuss implementation and quality improvement of the Health Homes, DM 3700 and ADA DM programs.

The Community Mental Health Centers (CMHCs) & Federally Qualified Health Centers (FQHCs) Integration Initiative allows CMHCs and FQHCs to partner. The goals of the Integration Initiative supports collaboration between CMHCs and FQHCs to integrate behavioral health services and primary care in the public health safety net system in order to improve access to: primary care for individuals with mental illness; behavioral health services for individuals with previously unrecognized and/or untreated mental health problems; and behavioral health supports for individuals who require assistance in effectively managing their chronic disease or improving health status.

The SUD Provider & FQHC Integrated Care Pilot Project will allow Behavioral Health Providers contracted by DBH to provide CSTAR services and FQHCs to partner. The goals of the pilot project will support collaboration between FQHCs and DMH Certified CSTAR Providers to integrate primary care and substance use treatment in the public health safety net system in order to: identify substance use concerns within the primary care environment; reduce health disparities; and change (improve, create) the working relationship between primary medical and specialty behavioral health.

Certified Community Behavioral Health Organizations (CCBHO) were developed from the Excellence in Mental Health Act sponsored by Senator Roy Blunt. It establishes for community behavioral health providers a place in federal statute, nation standards and cost related reimbursement. Missouri was one of eight states selected to participate in the CCBHC demonstration project that was initially a two years grant; however, was recently extended until September 13, 2019. Missouri has fifteen CCBHOs covering 88 of Missouri 114 counties. CCBHO requirements include serving designated populations of focus including children and adults with moderate to severe mental illness, adolescents and adults with moderate to severe substance use disorders, children in state custody who have behavioral health disorders, and veterans or members of the armed forces with a behavioral health diagnosis. CCBHOs are required to: Serve the populations of focus regardless of an individual's ability to pay, place of residence, homelessness, or lack of a permanent address., use evidence- based, best and promising practices, coordinate care and provide a comprehensives array of community behavioral health services, provide needed services to the populations of focus regardless of payment source or ability to pay, and measure and report outcomes on efficiency and effectiveness or services provided and health status of individuals served. The comprehensive array of behavioral health services , primary care screening and monitoring, case management, psychiatric rehabilitation and peer and family support services.

Emergency Room Enhancement (ERE) program is one component of the Strengthening Missouri's Mental Health System initiative approved by Governor Jay Nixon in 2013. The purpose of the ERE program is to engage target consumers into ongoing treatment, coordinating care for the whole person by addressing behavioral health, physical health and basic needs, reducing the need for future emergency visits, hospitalizations and reducing hospital stays. DMH provides funding to 15 regions across the state for the program. ERE now encompasses 101 of Missouri's 114 counties. Each of the 15 regions have partnered with local hospitals, community health centers, law enforcement agencies, substance use treatment facilities, and social service providers to coordinate care and remove barriers to individuals seeking treatment and services.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

The state supports a service system that provides health home services for individuals with co-occurring mental illness and physical health needs to include use of a primary care physician consultant and nurse care manager who ensure physical health needs are met for adults with serious mental illness and youth with serious emotional disturbance. Health home providers receive a per member per month payment under fee for service (FFS) or a perspective payment from the CCBHO demonstration to conduct metabolic screenings, determine needs and coordinate both mental and physical care for individuals served in the health home. Those providers implementing the evidence-based practice, Integrated Treatment for Co-occurring Disorders (ITCD), have access to additional service codes within the Medicaid rehab option program. Additionally, the state conducts fidelity reviews to ensure programs are following the evidenced model. For CSTAR substance use disorder programming, DMH developed higher rate billing codes for co- occurring disorder and trauma services to better compensate providers for higher staff qualifications.

The state also supports a service system that provides integrated treatment for through the CCBHO Project. The Centers for Medicare and Medicaid (CMS) have established guidelines for implementing a Prospective Payment System to purchase services from CCBHOs. Prospective Payment System (PPS) is a cost-based reimbursement which establishes a cost per visit for each CCBHO based on audited costs and proposed costs vs actual and proposed visits. A "visit" is a day in which an eligible individual receives an eligible services either face-to-face or via telehealth from an eligible provider. CCBHOs receive the same reimbursement regardless of the number of services provided during a visit. The goal is to eventually move all community mental health centers to a PPS billing model. Missouri supports a service system that provides Wellness Coaching for individuals with co-occurring mental illness or substance use disorder and physical health conditions. Wellness Coaching is a deliberate process using a set of techniques designed to focus on achieving or maintaining wellness. A Wellness Coach assists individuals in meeting their wellness goals by helping individuals clarify what they want to change or improve and guides the individual toward long lasting behavioral change by providing ongoing support and reinforcement.

DMH also partners and coordinates with the Missouri Primary Care Association, Missouri Hospital Association and Rural Health Association in order to increase communication and support each other through initiatives.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

N/A

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ◉ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Missouri DMH completed our parity exercises in partnership with the MO HealthNet, Missouri's Medicaid division and removed inappropriate limits for Mental Health and Substance Use Disorder services.

10. Does the state have any activities related to this section that you would like to highlight?

Missouri DMH is currently developing a model for integrated treatment by substance use providers that is designed for those with substance use disorders and a co-occurring mental illness to mirror services that are currently being provided by mental health providers. DMH is currently working with provider members to review and revise substance use disorder treatment programming. Integration of mental health services within the substance use disorder (SUD) treatment will not only more appropriately address these co-occurring disorders more effectively but also will include a mechanism to review and measure organizations against identified fidelity components moving providers along a continuum of improved integrated service delivery. DMH is currently working with provider members to review and revise SUD treatment programming including the Comprehensive Substance Treatment and Rehabilitation (CSTAR) program to examine the services through a best practice lens. CSTAR was developed by the DMH's Division of Behavioral Health (DBH) and is funded by Missouri's Medicaid program and DBH's purchase of service system. CSTAR provides a full continuum of care approach to SUD treatment offering a flexible combination of clinical and supportive services that vary in duration and intensity depending on the needs of the individual. However, this service delivery is based on an acute care model rather than a chronic care model. The acute care model and the fee-for-service model does little to adequately reimburse for or incentivize a chronic care model.

Please indicate areas of technical assistance needed related to this section

N/A

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	( ) Yes (•) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	( ) Yes (•) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes (•) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes (•) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes (•) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? (•) Yes ( ) No

7. Does the state have any activities related to this section that you would like to highlight?

The Department of Mental health is taking a critical look at its policies, practices, and outcomes. The goal is to understand where we are, and take actions to enhance equity in Missouri's public mental health system. The Mental Health and Inclusion Alliance was established to support the Department of Mental Health in actualizing and fulfilling its commitments to equitable access, inclusive services, and favorable outcomes for the people it serves. Mental Health Equity is the right to access quality mental health services for all populations. It is a structural and systemic concept that focuses on achieving comparable, favorable outcomes across racial and other groups through the allocation of resources in ways designed to remedy disadvantages some people face through no fault of their own.

The Alliance aims to help DMH and its provider network achieve and sustain equity by promoting fairness in policies, programs, initiatives, hiring & promotion practices, funding decisions, and consumer outcomes. To achieve these objectives the Alliance believes we must advance and embed equity and inclusion principles and practices in the mental health system. In addition, we must empower disadvantaged populations and stakeholders to participate in service system design and delivery, as well as policy development. The members of the Equity and Inclusion Alliance will deliver and help implement a Mental Health Equity and Inclusion Plan. Most of the work is being done by teams, called workgroups, with specific areas of focus.

More information online at: Mental Health Equity and Inclusion Alliance | dmh.mo.gov

The Division of Behavioral Health is taking steps to use data and commit resources to underserved populations and areas of the state. Through data we have identified the North St. Louis as an area with a high number of Opioid overdose deaths of African Americans. We are allocating some of the supplemental Block Grant funds to provide additional prevention, treatment and recovery support services to this area of the state.

The Missouri Behavioral Health Council has a Cultural Equity, Diversity & Inclusion committee that is actively providing education and supports to the behavioral health providers. DBH works closely with this committee.

Please indicate areas of technical assistance needed related to this section

N/A

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Missouri was chosen as a Certified Community Behavioral Health Organization (CCBHO) demonstration state with an implementation date of July 1, 2017. The CCBHO Demonstration grant was extended to September 2023. A State Plan Amendment (SPA) has been submitted to the Centers for Medicare and Medicaid Services (CMS) and has been approved to continue the Perspective Payment System (PPS). Incentive payments, quality measures and a focus on outcomes are all key components of this project. Missouri specifically chose evidence-based and promising practices as requirements for CCBHO inclusion. Those include medication assisted treatment (MAT), peer and family supports, and integrated treatment for co-occurring disorders (ITCD), among others.

In 2018, the Department of Corrections (DOC) was appropriated funds and collaborated with DMH to implement a comprehensive, community-based program for individuals under the supervision of DOC who have substance use and/or co-occurring disorders and mild to moderate mental illness, and are considered high risk for reoffending. The Improving Community Treatment Success (ICTS) program is unique in that it provides quarterly incentive payments to community behavioral health providers based on agreed-upon outcome measures to improve recovery and recidivism outcomes. Metrics include: (1) retention in treatment; (2) stable employment; (3) stable housing; (4) reduced probation revocations; and (4) reduced substance use violations.

Please indicate areas of technical assistance needed related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The Department of Mental Health (DMH) currently funds Coordinated Specialty Care (CSC) programs through Assertive Community Treatment (ACT) teams throughout the state, serving transition aged youth, including individuals with early and first episode psychosis. . The CSC programs provide a recovery-oriented approach that includes person-centered planning and shared decision-making. Program expectations are CSC treatment will be time- limited (two to three years) and linkages to community supports will be established to maintain recovery during and beyond treatment. Treatment may be extended in the CSC program, as clinically appropriate, using a step-down approach with eventual transition to traditional mental health services in the community.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

DMH promotes the use of evidence-based practices (EBP) for individuals and families experiencing ESMI by funding training opportunities for providers on EBP and funding to support programs through the initial startup of CSC programs using the ACT

model. ACT provides highly individualized, intensive, integrated services directly to individuals and families in their homes or communities.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

DMH chose the Coordinated Specialty Care (CSC) model through Assertive Community Treatment (ACT) for the 10 percent set-aside for ESMI. The CSC programs provide a recovery-oriented approach that includes person-centered planning and shared decision-making. Program expectations are CSC treatment will be time-limited (two to three years) and linkages to community supports will be established to maintain recovery during and beyond treatment. Treatment may be extended in the CSC program, as clinically appropriate, using a step-down approach with eventual transition to traditional mental health services in the community.

DMH providers also utilize EBPs including Motivational Interviewing, Empirically Supported Therapy, Supported Housing, Supported Employment and Education, Navigate, Illness Management and Recovery, Enhanced Illness Management and Recovery and Individual Resiliency Training to support consumer identified as ESMI.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

DMH will continue to focus on providing services using the CSC model and expand across the state. This will also include providing training on EBPs for ESMI such as Navigate Supported Employment and Education and Individual Resiliency Training.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

CSC programs are required to submit individual-specific data to DMH on a quarterly basis for every individual served. These data are entered into a database allowing the reporting of outcomes to be broken out by program and statewide.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnostic categories for ESMI include Adjustment Disorders, Anxiety Disorders, Impulse Control Disorders, Mood Disorders, Personality Disorders, and Psychotic Disorders.

Please indicate areas of technical assistance needed related to this section.

N/A

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Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Consumers and their caregivers are engaged through an individualized assessment and treatment planning processes that focus on recovery needs and preferences of the individual in all areas of life. The provider conducts active dialogue with the individual in order to know what the individual's needs and desires are in life to provide an array of services that would best help them reach their goals.

4. Describe the person-centered planning process in your state.

The expectation is that providers meet with the individual and the family/natural supports to assess their treatment needs and develop the recovery goals that the person wants while offering service interventions that can help the person achieve said goals. The treatment team provides input and develops a written treatment plan that is reviewed by the individual and the individual receives a copy. The expectation is that the treatment plan is revised and updated on an ongoing manner to reflect achievement of goals/objectives and the addition of any new goals and objectives throughout the year. In efforts to enhance the quality of person-centered planning the department continues to streamline assessment processes. More time is allowed for development of the person-centered plan so the providers have more time to become familiar with the individuals and understand their needs. Requirements for an annual assessment have been reduced to lessen the burden for individuals, better promote early engagement in services, and allow service providers more time to focus on treatment needs rather than documentation.

Please indicate areas of technical assistance needed related to this section.

N/A

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health implemented an annual SABG monitoring of DBH contracted providers. The Division has checks and balances to ensure block grant funds are spent appropriately, for example, making available a menu of services that may be provided, setting up controls within our billing portal to ensure accurate billing and a comprehensive system is in place between clinical, fiscal and monitoring entities within the Division to ensure contract compliance. The billing system allows us to run utilization reports that are used to identify and correct any areas of concern. The DBH also collects data from provider organizations for block grant reporting.

Please indicate areas of technical assistance needed related to this section

N/A

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Missouri does not have any federally recognized tribes.

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☑ Rural communities
- ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

The Division of Behavioral Health (DBH) supports various targeted initiatives in the state based on need. Prevention providers must submit an annual Strategic Work Plan using the Strategic Prevention Framework. As part of the plan they must conduct a community needs assessment and coalition assessments. Based on their assessments, the providers choose the top priorities to work on for the planning year. Examples of targeted initiatives include education on alcohol, tobacco, marijuana, and prescription drug misuse, mentoring programs for at-risk youth, and after school programs for at-risk youth.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

DBH and the Missouri Credentialing Board worked together to establish a three-tiered credentialing process to reach the entire spectrum of prevention professionals. All three levels of credentialing are marked by training, experience, and education. DBH requires that all contracted prevention programs obtain at least the first credential level.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

DBH provides technical assistance and training to contracted prevention providers. Training needs are assessed across the state and necessary assistance to help prevention staff and programs is provided for them to be successful.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Primary Prevention providers are required to assess the community readiness as a part of their annual Strategic Work Plan. The providers use the Tri-Ethnic Center Community Readiness Survey.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The Division of Behavioral Health (DBH) requires providers to use evidence-based programs and environmental strategies. DBH uses the following definition for evidence-based programs: 1) Inclusion in a federal list or registry of evidence-based interventions, 2) reported (with positive effects) in a peer-reviewed journal and 3) documentation of effectiveness based on that the intervention is based on a theory of change that is documented in a clear logic or concept, is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature, is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to identifying and selecting evidence-based interventions, scientific standards of evidence and with results that show a consistent pattern of credible and positive effects and

is reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

Missouri uses the Strategic Prevention Framework model to implement the four guidelines. The process includes: 1) Assessment of the community's needs, 2) Capacity building to mobilize and address the needs of the community, 3) Development of a prevention plan to identify the activities, programs and strategies necessary to address the needs, 4) Implementation of the prevention plan, and 5) Evaluation of the results to achieve sustainability and cultural competence.

Missouri identified appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Prevention Technology Transfer Center Network and SAMHSA's Center for Substance Abuse Prevention.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Prevention providers disseminate ATOD information within their communities. . Partners in Prevention disseminates ATOD information to the 24 College campuses statewide with which they work. Examples include fact sheets on prescription drug misuse, information on drug trends, media campaigns, and county level data fact sheets.

b) Education:

Prevention providers work with school districts in their area to provide evidence-based programming that is specific to their needs such as the Too Good for Drugs, PeaceBuilders, and Second Step curriculum. After school programming for high-risk youth, mentoring programs and heroin-specific education is offered.

c) Alternatives:

Prevention providers work with their local communities and coalitions to provide alternative drug free activities such as family dances, lock-ins, and Safe and Drug Free Halloween events and New Year's Eve celebrations.

d) Problem Identification and Referral:

The school-based providers provide referral and assessment services as needed. The statewide prevention provider that works specifically with the deaf and hard of hearing population makes referrals to treatment centers as needed; however, this provider has multiple funding sources and referrals to treatment centers are not with SABG funds.

e) Community-Based Processes:

All prevention providers collaborate with other agencies and coalitions in their communities to provide effective programming that meets their needs. Prevention providers and local coalitions collaborate to conduct Town Hall meetings on topics such as underage drinking, prescription drug misuse, and Heroin. Prevention providers assist coalitions with developing and distributing their information in ways of direct mailings, brochures, info packets, websites, coalition advertising and marketing.

f) Environmental:

Prevention providers work with their local communities, coalitions and elected officials to work on city/county ordinances, school district policies and state policies. Efforts have included local prescription drug monitoring programs and creating city ordinances that increased the age to purchase tobacco products to 21. The prevention providers that receive funding from the block grant provide technical assistance and education to their local communities and coalitions, building their capacity to help make change in their communities. The local coalitions work on city/county ordinances, school district policies and state policies without funding from the Department of Mental Health and without funding from the SABG.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

All prevention providers submit an annual Strategic Work plan, year end report, and a budget at the beginning and end of the state fiscal year. They also submit a monthly report to DBH detailing the services provided that month. Annual reviews are conducted on all prevention providers to make sure they are in compliance with contract requirements.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

The evaluation plan for substance use disorder prevention is included in the strategic plan for prevention document uploaded to the attachment page.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☑ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☐ Heavy use
- ☑ Binge use

- [x] Perception of harm
- **c)** [x] Disapproval of use
- **d)** [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **e)** [ ] Other (please describe):

Footnotes:

STRATEGIC PLAN FOR PREVENTION

2020-2025

DEPARTMENT OF MENTAL HEALTH * DIVISION OF BEHAVIORAL HEALTH

The Missouri Division of Behavioral Health manages programs and services for people who need help for a mental illness or alcohol or drug problem. Services available are prevention, education, evaluation, intervention, treatment, and rehabilitation.
The Division of Alcohol and Drug Abuse (ADA) was created in 1975 and established in statute in 1980 (RSMo 631.010) as part of the Department of Mental Health. In spring 2013, the Divisions of Comprehensive Psychiatric Services and Alcohol and Drug Abuse merged into one division, the Division of Behavioral Health (DBH).

DBH Prevention Priorities

The Division's prevention program covers all segments of the population at potential risk for drug and alcohol use. However, the primary focus is on children who have not yet begun use. Research finds that brain changes caused by drinking before age 15 could predispose adolescents to a lifetime of alcohol dependency. Children are drinking earlier and at more dangerous levels than they did many years ago.

Prevention Goals

Create positive community norms, policy change, reduced alcohol, tobacco and other drug availability, and increased enforcement at the state and community level through the implementation of effective, evidence-based prevention programs and environmental strategies to prevent and reduce substance use and its consequences for youth, adults and families in Missouri.

Prevention Objectives

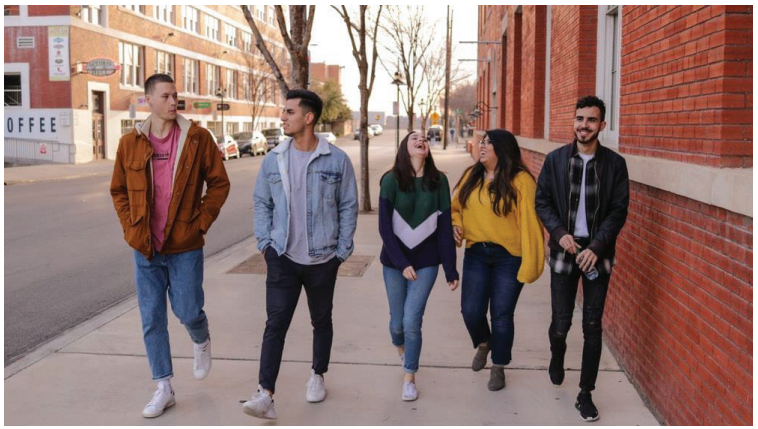
- By FY 2025, consequences of substance use in Missouri will be reduced as a result of prevention programs implementing effective and evidenced-based programs and strategies and the Strategic Prevention Framework.
    - Reduce alcohol, tobacco and marijuana use among youth.
    - Reduce alcohol and drug use, including opioid misuse, among general population.
    - Reduce unnecessary accidents and emergency room visits.

Prevention Outcomes

- Reduced accidents and emergency room visits and hospitalization as a result of alcohol consumption by youth and adults.
- Reduced accidents and emergency room visits and hospitalization related to marijuana and other drugs by Missouri's youth and adults.

Programs and Numbers Served

Contracted Prevention Providers	Number of Programs	Numbers Served
Prevention Resource Centers	11	346,767
Direct Programs/Services	7	6,274
School-Based Programs (Schools served)	38	10,400
College-Based Program/Services	1	190,425
Deaf & Hearing Impaired Services	1	6,078
Partnerships for Success	5	72,541



DBH Prevention Targets

Binge Drinking: By FY 2025, reduce binge drinking among Missouri's youth and young adults from FY 2018 baselines.

- The percentage of Missourians age 12 to 20 who engaged in binge alcohol use in the past month was higher than that for the United States (13.33% vs. 11.24%) (NSDUH, 2018-2019).
- Students who binge drink are at increased risk of being assaulted (including sexually) or injured, or experiencing academic and legal problems (U.S. Department of Health and Human Services, 2007).

Current Use of Alcohol: By FY 2025, reduce use of alcohol among youth in past 30 days from FY 2018 baselines.

- Missouri's youth ages 12 to 17 are drinking at rates similar to that of the nation as a whole (NSDUH, 2018-2019).
- Research indicates that individuals who start drinking early in life are at increased risk to develop alcohol addiction and to incur alcohol-related injuries later in life (Hingson et al, 2000; Hingson et al, 2006).
- In a given year, about 7,600 Missourians receive treatment for alcohol use disorders through the Missouri Division of Behavioral Health. (Smith et al, 2020).
- In 2020, approximately 34,000 hospital and emergency room admissions across the state were alcohol-related (Smith et al, 2020).

Current Use of Marijuana: By FY 2025, maintain or reduce use of marijuana among youth in past 30 days from FY 2018 baselines.

- While current rates of marijuana use is lower than the national average across all age groups (NSDUH, 2018-2019), medical marijuana was legalized in Missouri in 2018. The state's first dispensary opened in October 2020 in St. Louis. This increased availability raises concerns for increased use in Missouri youth.
- In a given year, about 4,200 Missourians receive treatment for marijuana use disorders through the Missouri Division of Behavioral Health. (Smith et al, 2020).

Substance Use Onset: By FY 2025, delay onset of first use of alcohol and marijuana among youth from FY 2018 baselines.

- Among Missouri students who have ever used alcohol, the average age of first use is 13.4. The average age of first use of marijuana is 14.3 (Missouri Student Survey, 2020).

Youth Use of Tobacco: By FY 2025, reduce smoking and other tobacco use among Missouri's youth from FY 2018 baselines.

- Missouri's youth ages 12 to 17 are smoking at a higher rate than compared to that of the nation (3.41% in the past month vs. 2.50%) (NSDUH, 2018-2019).
- More Missouri youth use e-cigarettes / vapes than standard cigarettes (past month use 21.1%) (Missouri Student Survey, 2020).
- An estimated 9,768 Missourians die each year from smoking (Smith et al, 2020).
- Smoking has been implicated in a number of diseases including various cancers, respiratory diseases, fertility and pregnancy complications, cataracts, hip fractures, low bone density, and peptic ulcer disease (U.S. Department of Health and Human Services, 2004).

Youth Access to Tobacco: Continue to meet the requirements of the Synar Amendment for reducing the sale and distribution of tobacco products to individuals under the age of 18.

- The federal Synar regulation requires all states to reduce the number of successful illegal purchases by minors to no more than 20 percent of attempts in each state per year.
- Missouri has reduced the percentage of its retailers failing tobacco checks from 40 percent in 1996 to 7.5 percent in 2020 – as measured by the state's annual Synar survey.

Current Misuse of Prescription Drugs / Opioids: By FY 2025, reduce prescription misuse (with a focus on opioids) among Missouri's youth from FY 2018 baselines.

- Statewide, all drug overdose deaths increased approximately 17% in 2020 compared to 2019. Opioid-involved drug overdose deaths represent the majority (73%) of total drug overdose deaths in Missouri. (MO Department of Health and Senior Services, 2020)
- Missouri's youth ages 12 to 17 and adults 18+ are misusing pain relievers a higher rate than compared to that of the nation (2.74% in the past year vs. 2.53% and 3.80% in the past year vs. 3.69%) (NSDUH, 2018-2019).

Risk Awareness: By FY 2025, increase the number of youth who perceive risk/harm of alcohol, cigarettes and marijuana from FY 2018 baselines.

- A significant number of Missouri youth believe that there is *only a slight risk at most* if they engage in binge drinking (24.1%), smoking a pack of cigarettes per day (18.9%), using e-cigarettes (33.2%) or smoking marijuana (39.2%) (Missouri Student Survey, 2020).
- The percentage of Missourians 18+ who believe binge drinking (39.85% vs. 45.00%), smoking cigarettes (66.16% vs. 72.15%) and smoking marijuana (20.22% vs. 24.56%) is a "great risk" is lower than the national average (NSDUH, 2018-2019).

Current Use of Methamphetamine: By FY 2025, reduce methamphetamine use among Missouri's adults from FY 2018 baselines.

- Missouri adults 18+ are using methamphetamine at a higher rate than the national average (.94% vs .76%) (NSDUH, 2018-2019).
- In a given year, about 7,500 Missourians receive treatment for methamphetamine use disorders through the Missouri Division of Behavioral Health. (Smith et al, 2020).

Missouri Prevention NOMs

Prevention NOMs	Ages 12-17			Ages 18+		
	Year 1	Year 2	Year 2-1 Variance	Year 1	Year 2	Year 2-1 Variance
30-day Use						
Alcohol+	10.8%	9.2%	-1.6%	55.0%	53.6%	-1.4%
Cigarettes+	5.2%	3.4%	-1.8%	23.0%	21.4%	-1.6%
Other Tobacco Products+	7.3%	5.1%	-2.2%	29.1%	26.1%	-3.0%
Pain Relievers+	3.5%	2.7%	-0.8%	4.4%	3.8%	-0.6%
Marijuana+	5.8%	5.9%	0.1%	8.7%	9.3%	0.6%
Illegal Drugs Other than Marijuana+	8.3%	7.5%	-0.8%	10.6%	10.9%	0.3%
Perception of Risk						
Alcohol (no dosage given)*	60.21%	53.55%	-6.66%			
Cigarettes (1+ pack per day)*	83.05%	81.09%	-1.96%			
E-Cigarettes / Vapes (no dosage given)*	58.20%	66.80%	8.60%			
Marijuana (no dosage given)*	63.07%	60.76%	-2.31%			
Prescription Drug Misuse*	87.02%	85.79%	-1.23%			
Binge Drinking Once or Twice a Week+				40.7%	39.9%	-0.9%
Smoking Marijuana Once a Month+				24.5%	20.2%	-4.3%
Smoking One or More Packs of Cigarettes Per Day+				67.5%	66.2%	-1.3%
Age of First Use						
Alcohol*	12.90	13.36	0.46			
Cigarettes*	12.68	13.23	0.55			
Marijuana*	14.18	14.31	0.13			
Prescription Drug Misuse*	11.63	11.20	-0.43			
Disapproval of Youth Use						
Alcohol*	67.6%	67.0%	-0.6%			
Cigarettes*	87.1%	87.7%	0.6%			
E-Cigarettes / Vapes*	76.9%	77.1%	0.2%			
Marijuana*	79.2%	75.0%	-4.2%			
Prescription Drugs*	94.8%	94.5%	-0.3%			

**Missouri Student Survey, Year 1 = 2018, Year 2 = 2020*

+NSDUH, Year 1 = 2016-2017, Year 2 = 2018-2019

Green highlight indicates change in the desired direction

Prevention Strategies and Activities

The Division of Behavioral Health contracts with various prevention agencies across the state to plan and implement prevention strategies and programs. The state's investment in the infrastructure of the Substance Use Prevention Network, Prevention Resource Centers (PRC), and the Partners in Prevention program on state college campuses, positions Missouri to achieve population-level changes in substance use patterns locally and across the state. The Prevention Resource Centers scope of work incorporates the Strategic Prevention Framework as well as many other specific elements to promote positive prevention outcomes.

These funded programs are required to:

- Develop, implement and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.
- Utilize data to identify prevention needs, gaps, and resources.
- Implement evidence-based programs and strategies that address identified gaps and needs. Implement strategies with fidelity.
- Implement the Strategic Prevention Framework.
- Evaluate services and progress toward outcomes.
- Have formal agreements with multiple community-level partners to collaborate in community planning and implementation.
- Select and implement prevention practices that are culturally appropriate.
- Select a comprehensive package of evidence-based strategies that are likely to have a positive impact on the community. The selected strategies should address one or more of the Center for Substance Abuse Prevention's six core strategies.
- Address sustainability.
- Report NOMs data and other information to DBH in a timely manner.
- Participate in public policy and advocacy support and training.
- Promote a unified prevention message across the state and collaborate on media campaigns.
- Implement tobacco merchant education to retailers (PRCs).
- Be a DBH certified program, which means each funded program must be in compliance with the Core Rules for Psychiatric and Substance Abuse Programs, General Program Procedures, and the Certification Standards for Alcohol and Drug Abuse programs.

Funded program staff are required to:

- Meet DBH Certification Standards for Personnel.
- Acquire and maintain the Missouri Prevention Specialist (MPS) credential.
- Participate in Substance Abuse Prevention Specialist Training (SAPST).

- Use data to identify local needs and develop strategic plans.
- Assess effectiveness of prevention strategies.
- Conduct evaluation and monitor progress toward goals.
- Plan for workforce development.

Other Strategies and Activities

- **Show Me Zero Suicide Initiative Grant**
  Aims to reduce youth suicide through an integrated systems-level approach, which includes establishing a continuity of care model for youth at risk of suicide and promoting the adoption of suicide prevention as a core priority of youth-serving institutions, such as hospitals and schools. Through collaboration with these organizations, this initiative is effectively identifying youth ages 10-24 who are at risk for suicide and providing them immediate linkage to intensive services and follow-up care.

  Services are being focused on a five-county region in western Missouri, centered on Jackson County, which includes Kansas City, as well as surrounding counties with more rural areas.
  The overall aim of the *Show Me Zero Youth Suicide Initiative* is to reduce suicides and suicide attempts by accomplishing three major goals:
  1) Improve the system of care of suicidal youth who use hospital emergency departments, in-patient psychiatric facilities, and/or crisis hotlines.
  2) Improve the capacity of school systems to identify, respond, and refer youth at risk of suicide.
  3) Strengthen overall prevention efforts for at-risk youth populations in other settings.

- **Signs of Suicide (SOS) Training**
  DMH contracted Prevention Resource Center (PRC) staff have been trained as SOS Trainers. The PRC's provide this training to school staff across the state.

- **Zero Suicide Initiative**
  The Coalition for Community Behavioral Healthcare, in collaboration with DMH and the national Suicide Prevention Resource Center, has hosted a Show Me Zero Suicide Learning Collaborative for Community Mental Health Centers the last two years with another one planned next year. DMH facilities are also being educated on the Zero Suicide framework.

- **Partnerships for Success Grant**

  In 2020, DMH was awarded a five-year Partnerships for Success grant to target substance use among youth ages 12 to 18 and methamphetamine use in adults in 81 counties in Missouri. A resiliency approach is being used to reduce risk factors and promote protective factors common to alcohol,tobacco, and other drug use, including prescription drug misuse. Missouri's program is designed to 1) enhance protective factorsand reverse or reduce risk factors, 2) address all forms of substance use, 3) enhance substance use workforce skills, and 4) present consistent, community-wide messaging. Interventions target the individual, family, and community ecological levels tosupport positive youth development and are based upon the Strategic Prevention Framework.

- **Missouri Heroin Overdose Prevention and Education (MO HOPE) Project**

  In 2016, DMH was awarded a 5-year federal grant to directly address the opioid crisis through overdose education and naloxone distribution. Priority area is the Eastern Region.

- **State Opioid Response Grant**

  DMH was awarded a federal grant to improve access to evidence-based practices in prevention, treatmentand recovery specific to opioid misuse.

  Prevention initiatives include:

  - Overdose education and naloxone distribution
  - ECHO expert panelists will educate providers about the treatment of chronic pain.
  - Generation Rx program will be implemented in schools in St. Louis and Springfield to educate on medication safety, etc.
  - Mentoring and wraparound services will be provided through Big Brothers Big Sisters of Eastern MO for particularly African American males ages 5-25 that reside in North St. Louis City, St. Louis County, Cape Girardeau County, and Scott County.

- **Mental Health First Aid (MHFA)**

  DMH contracted Prevention Resource Center (PRC) staff have been trained as Adult and Youth MHFA Trainers. The PRC's provide this training across the state.

Implementation Plan

All DBH contracts for prevention services are in place for one year, from July 1st until June 30th the following year. Contracts are monitored on a monthly basis by state-level prevention staff. Contracts are renewed annually based on availability of funding, fulfillment of contract terms, and effectiveness of services.

Prevention Resource Centers are required to submit a Strategic Work Plan to DBH annually for approval. Once approved, these plans are monitored by DBH staff to ensure progress toward identified goals.

Efforts through Block Grant funding and the 2020 Partnerships for Success grant are being made to increase training for the Prevention Resource Centers and fill gaps as determined by the bi-annual Workforce Development Survey.

The Statewide Epidemiology Workgroup will assist the state in making the link between the data they generate and the prevention objectives outlined, as well as providing local programs with data that drives the selection of their program strategies that will also address the statewide targets.

Prevention Infrastructure Goals

- DBH will ensure that prevention services are part of a recovery-oriented system of care.
- DBH will ensure that treatment and prevention services are linked with broader healthcare and social service systems.
- DBH will continue working with the prevention resource centers and coalitions to broaden their scope of work to include preventing mental, emotional, and behavioral disorders, as many of the risk and protective factors overlap, and continue linking them withpotential opportunities.

DBH will continue to require contracted prevention providers to submit demographic data to DBH monthly. The data collected is used to complete the Prevention sections of the Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant application, special requests from National Association of State Alcohol and Drug Abuse Directors, Data Consolidated Coordinating Center, Center for Substance Abuse Prevention, and for state-level reporting.

Workforce Development

Missouri has made significant steps in preparing the substance use prevention workforce by establishing a credentialing process. The Division of Behavioral Health and the Missouri Credentialing Board (MCB) worked together to establish a three-tiered credentialing process to reach the entire spectrum of prevention professionals. All three levels of credentialing are marked by training, experience and education. Missouri has over 160 prevention professionals with a credential. The Division of Behavioral Health requires that all funded prevention programs obtain at least the first credential level. MCB coordinate trainings across the state to assist individuals in acquiring the skills and experience needed to move across credentialing levels. More information about the three credential levels can be found at www.missouricb.com.

Prevention workforce characteristics have significant implications for prevention programming. The strategic prevention framework is a rigorous model that requires an understanding of prevention science and the ability to perform numerous capacity building, program management, and evaluation activities. To ensure the workforce is adequately trained, the first Workforce Development Survey was administered in 2019. DBH has begun providing trainings to address gaps uncovered by the survey and will assess these efforts by repeating the survey in 2021.

Evaluation Plan

The move to science-based prevention called for sound approaches to needs assessment, resource allocation, program monitoring and improvement, and documentation of prevention outcomes. Evaluation activities are integral to program management and to the Strategic Prevention Framework. Evaluation efforts should provide support for the planning, implementation and improvement of prevention efforts in Missouri. At the beginning of the programming process, needs must be assessed and programs and strategies must be identified to address needs. Once programs have been implemented, evaluation efforts can serve to assess the degree to which prevention efforts have been successfully implemented.

Local Level:

- Prevention Resource Centers (PRCs) annually conduct a community needs assessment to assist in developing their strategic work plans. PRCs evaluate their programs for effectiveness.

State Level:

- Assure Data is available to communities by monitoring state and local drug trends:
  - Missouri Student Survey and Report
  - ADA Status Report
  - Missouri Data Querying Site
- DBH contracted prevention providers will submit demographic data to DBH.
- DBH monitors local prevention providers for quality of service delivery and fidelity.
- DBH and Discretionary Grants provide training on evaluation skills and techniques.

The Division of Behavioral Health will provide data analysis in support of a Prevention Needs Assessment. DBH will continue to annually publish the *Status Report on Missouri's Alcohol and Drug Misuse Problems*. This report is updated annually and issued online by DMH. The purpose of this document is to support research, education, policy-making, planning, and evaluation activities. As a reference tool, the report provides consistent sets of year-to-year data on alcohol and drug usage rates and reported events that result from substance use. In addition, DBH has developed an online reporting website for the Missouri Student Survey, a biannual consumption and risk and protective factor survey of students ages 12-17. This will allow all communities in Missouri to locate and run basic analyses on the data, drilling down to the local level.

The State Epidemiology Workgroup (SEW) will assess data trends and geographical variations to develop an assessment of prevention need in the state and prepare an annual summary report prioritizing areas of need. The work by the SEW will help coalitions conduct needs assessments, planning, and subsequent evaluations. The SEW will continue to monitor drug trends across the state. The SEW will assist the state in making the link between the data that they generate and the prevention objectives outlined, as well as providing local programs data that drive selection of local program strategies that will also address the statewide targets.

The Division of Behavioral Health has a longstanding partnership with the Missouri Institute of Mental Health who is dedicated to providing research, evaluation, policy and training expertise to the Department and other organizations.

Synar

DBH will continue to ensure that Missouri stays in compliance with the Synar Amendment and will maintain a retailer violation rate lower than 20%. Contracted PRCs will continue to provide merchant education to tobacco retailers across the state. DBH will continue to collaborate with the Division of Alcohol and Tobacco Control (ATC) on enforcement and training efforts.

% of MO Retailers Failing Tobacco Checks		Meet Synar?
2020	7.5%	yes
2019	7.8%	yes
2018	6.3%	yes
2017	13%	yes
2016	7.7%	yes
2015	11.3%	yes
2014	7.2%	yes
2013	7.4%	yes
2012	10.4%	yes
2011	10.2%	yes
2010	10.6%	yes
Baseline 1996	40.30%	N/A

Calendar year is provided.

Sustainability

DBH ensures that activities are sustainable by training funded programs and coalitions in approaches that promote sustainability at every step of the Strategic Prevention Framework. Funded programs will be expected to build sustainability into their data collection process, plan and approach by building community readiness; seeking buy-in from community leaders; using evidence-based approaches that are monitored and evaluated; leveraging funds whenever possible; and collaborating with local prevention partners. Centralizing prevention data is also an essential component of sustainment. A good beginning was made with the SEW and the Strategic Prevention Framework State Incentive Grant. The DBH Status Report, DHSS's MICA system and the Missouri Student Survey are ongoing data resources for agencies and communities. Also, DBH has developed a data querying site that is available to the public.

DBH will continue to develop Missouri's prevention workforce. DBH will also continue to offer workforce development opportunities.

DBH will continue to partner with other state agencies/groups providing prevention services across the state to leverage funds and opportunities whenever possible. These agencies include but are not limited to: the Department of Health and Senior Services, Department of Elementary and Secondary Education, Division of Highway Safety, and Department of Public Safety.

DBH will continue working with the PRCs and community coalitions to broaden their scope of work to include preventing mental, emotional, and behavioral disorders, as many of the risk and protective factors overlap, and continue linking them with potential opportunities.

Cultural Competence

Through current projects DBH continues to develop the understanding needed to guide the identification and implementation of culturally, competent, evidence-based programs and strategies following the assessment of risk and protective factors, readiness, assets and resources, and priorities. Staff and funded program staff should be familiar with local communities' cultures and languages, and also have additional cultural skills and knowledge that lend them to working with any new emerging cultural situations which may present them. Training is provided to staff and funded program staff as needed.

The State Advisory Council for the Division of Behavioral Health will continue to contribute to the process of identifying culturally responsive, evidence-based programs and strategies. Also, DBH and MIMH have extensive experience implementing and evaluating culturally appropriate/competent prevention interventions. DBH will conduct annual assessments of the prevention system to ensure that programs, policies, and services are offered in ways that are meaningful to recipients consistent with their cultural world views. DBH will continue to devise strategies that enhance and guarantee cultural competence throughout the system.

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Division of Behavioral Health (DBH) supports and expects a variety of basic and evidence based services within the mental health service system for individuals with serious mental illness and children and youth with serious emotional disturbance including community support services, peer and family support services, medication services, school based services, disease management and health homes in order to assist individuals in managing their mental and physical health conditions while being supported to live in the community. Evidence based practices are supported and encouraged, such as assertive community treatment, integrated treatment for co-occurring disorders, and supported employment, which are shown to increase outcomes for individuals receiving evidence based services. The Division of Behavioral Health expects providers to have an array of housing options and intensive services in order to keep individuals in the housing of their choice.

Treatment Family Home – "home-like" setting in which intensive therapeutic mental health interventions are provided.

Professional Parent Home – "home-like" setting that provides intensive therapeutic mental health interventions for a child. Only one child is placed in a Professional Parent Home.

Intensive Evidence Based Practice – This service includes implementation of supports for treatments that have been proven demonstrably effective for children.

Psychosocial Rehabilitation – A combination of goal-oriented and rehabilitative services provided in a group setting to improve or maintain the individual's ability to function as independently as possible with their family or community.

Day Treatment – This service offers an alternative form of care to children who have serious emotional disturbance and who require a level of care greater than can be provided by the school or family, but not as intensive as inpatient service.

Family Assistance – These services are provided for the child and/or family. Activities provided in the delivery of services may include home living and community skills, communication and socialization, leisure activities for the child, arranging for appropriate services and resources available in the community.

Peer Support Services – Peer support services are delivered by individuals who have been successful in recovery from mental and/or substance use disorders who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support services help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Family Support – Services are provided for a family member of a child who had or currently has a behavioral or emotional disturbance disorder and may involve a variety of related activities to the development or enhancement of the services delivery system.
Youth Peer Support – Support services provided by certified Youth Peer Supports to consumers ages 13 to 25 to support, encourage, and model positive self-advocacy, recovery and resiliency.

Community Support – Services are designed to coordinate and provide services and resources to individuals and their families as necessary to promote resilience.

Targeted Case Management – This services includes arrangement, coordination and participation in the assessment to ensure that all areas of the individual's and family's life are assessed to determine unique strength and needs.

Respite – Temporary care provided by trained, qualified personnel, on a time-limited basis, for the purpose of meeting family needs and providing mental health stabilization.

Wraparound – providing direct and indirect service to assist in maintaining the child in regular home, school and/or community placement to ensure the functional success of the child in the community. Types of services may include basic needs supports, transportation supports, social-recreational supports, clinical/medical supports and other supports.

Assertive Community Treatment (ACT) – provision of multiple types of services to adults with serious mental illness and transitional age youth (TAY) with serious emotional disturbance which are received within their own home 24 hours per day, 7 days a week. Services provided to TAY are round-the-clock staffing of psychiatric unity, but within the comfort of their own home and community.

Integrated Treatment for Co-occurring Disorders (ITCD) – Evidence-based model of treatment for people with serious mental illnesses and co-occurring substance use disorders where combined treatment is received for mental illness and substance use disorders.

Intensive Home-based Services for Adults and Transition Aged Youth - Medically necessary services/supports are provided to adults who have a serious mental illness and are transitioning from an inpatient psychiatric hospital to the community, or who are at risk of returning to inpatient care due to their clinical status or need for increased support. Services and supports are provided in the individual's natural home. The home/program is structured to meet individual needs to ensure safety and prevent the individual's return to a more restrictive setting for services. Settings can include intensive residential treatment, psychiatric individualized supported living and/or clustered apartments.

Inpatient Diversion - a full array of intensive clinical services, delivered in a highly supervised, 24-hour structured therapeutic environment. This services is designed to avoid the need for hospitalization while working to restore an individual to a higher level of functioning, decrease risk of harm and prepare for transition to a less restrictive setting.

Housing Supports - Housing is a critical component for recovery and wellness. The DMH Housing Unit coordinates both state and federal funds to provide direct rental assistance to individuals and families with mental illness, substance use disorders, developmental disabilities, and HIV/AIDS who are homeless or experiencing housing crisis. The DMH believes that housing is key to helping Missourians with disabilities and their families attain self-determination and independent living. A full array of housing options are available from residential care facilities to independent apartments.

Supported Community Living programs are provided for approximately 2,700 persons with mental illness who do not have a place to live or who need structured services.

Intensive Community Psychiatric Rehabilitation Residential (ICPR RES) is comprised of medically necessary on-site services for adults who have been unsuccessful in multiple community settings and/or present an ongoing risk of harm to self or others.

In addition, the state supports diversionary programs that help individuals who are not currently engaged in services, but who access the health/hospital systems frequently such as Missouri's Health Care Home (HCH) initiative. The HCH initiative enhances the existing psychiatric rehabilitation program by adding nurse care managers (NCM) and a primary care physician (PCPC) consultant to each community mental health center. Enhancing the psychiatric rehabilitation teams with a NCM and PCPC, provides the access to a wealth of care management reports designed to help them both identify treatment gaps and to assist individuals in developing healthy lifestyles and managing their chronic illnesses. The Disease Management Projects currently in place are the result of collaboration between the Department of Mental Health (DMH) and the state Medicaid agency, MO HealthNet. The DM 3700 Project started in November 2010 and identifies Medicaid- enrolled adults with a serious mental illness and high medical costs who were currently not engaged in treatment at a Community Mental Health Center (CMHC). The ADA DM Project was implemented in 2014 through a partnership with DSS/MHD and DMH/DBH. In August 2020 in an effort to stay current with best practices and use the most appropriate language ADA DM was renamed SUD DM. SUD DM identifies Medicaid-enrolled adults with substance use disorders and high medical costs who were not currently engaged in treatment. DMH funds outreach efforts and the state Medicaid agency funds behavioral health treatment. Emergency Room Enhancement (ERE) was designed to prevent unnecessary hospital admissions and/or extended psychiatric hospitalizations for adults and are piloting ERE for youth. The program is intended to increase behavioral health care access for citizens who use the emergency room seeking treatment for psychiatric conditions and/or substance use disorders. Each ERE region has partnered with local hospitals, community health centers, law enforcement agencies, substance use treatment facilities, and social service providers to coordinate care for the whole person by addressing behavioral, physical and basic needs.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a) Physical Health — (•) Yes ( ) No

b) Mental Health — (•) Yes ( ) No

c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Case management services are the arrangement and coordination of an individual's treatment and rehabilitation needs. This includes other medical, social, and educational services and supports; the coordination of services and support activities. Case Management also includes the monitoring of services and support activities to assess the implementation of the client's individualized plan and progress towards outcomes specified in the plan. Clients are escorted to services when necessary to achieve desired outcomes or to access services. Direct assistance is provided to the child, family, and/or adult including coaching and modeling of specific behaviors and responses (the direct assistance may not involve individual or family counseling or psychotherapy).

4. Describe activities intended to reduce hospitalizations and hospital stays.

Activities designed to reduce hospitalizations include illness management, crisis prevention, assertive community treatment and wellness coaching interventions that are individualized to each person's situation. Intensive services are wrapped around individuals who have been less successful in community living such as services provided in the home that assist with daily living and symptom management. Additional activities include the expansion of the State Emergency Room Enhancement program to include children and youth is currently being piloted, with specific goal of reduction of acute hospitalization for children and youth.

Crisis Stabilization Units/Centers provide intervention and assistance for law enforcement, Community Behavioral Health Liaisons, and hospitals to connect someone in a behavioral health crisis, possibly preventing the individual from entering the criminal justice system and diverting them to community-based treatment most appropriate for their level of need. In 2021, Missouri dedicated approximately $15 million in state funding which will expand this program by adding 12 new regional CSU locations to five existing CSUs (providing at least one in each Missouri State Highway Patrol troop).

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.5%	
2.Children with SED	7%	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Statewide prevalence for adults with Serious Mental Illness (SMI) was obtained from the 2018-2019 National Survey on Drug Use and Health (NSDUH) State Prevalence Estimates. Statewide prevalence for children with Serious Emotional Disturbance (SED) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Missouri does not have estimates on incidence for SMI or SED.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

The State of Missouri is divided into service areas some of which include rural areas. Providers established a number of service sites within these service areas in an effort to efficiently and effectively serve individuals in rural areas. Telehealth has also become an important and efficient factor in delivering services to the rural populations. Additionally, staff drive to individual's homes to provide services when individuals are not able to come to service sites.

b. Describe your state's targeted services to the homeless population.

The Division of Behavioral Health supports Projects for Assistance in Transition from Homelessness (PATH) programs which supports services to individuals who have mental illness or substance use disorders who are homeless or are at risk of being homeless. Additionally, the Division of Behavioral Health provides Shelter Plus Care rental assistance to over 2,000 households monthly. These are Continuum of Care, permanent supportive housing projects that serve literally and chronically homeless households. These projects span 89 of the 114 counties in Missouri. DBH also provides the Rental Assistance Program which creates and sustains project based rental assistance for homeless individuals in recovery as well as one-time assistance to create housing opportunities for households experiencing housing crisis. Also, data indicates the emergency room enhancement project has positively impacted the homeless population.

c. Describe your state's targeted services to the older adult population.

Older adults are included within our normal service system.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The State of Missouri receives annual State of Missouri allocations to fund provider organizations in the delivery of mental health services. Provider organizations identified as Administrative Agents receive allocations to support the uninsured, underinsured as well as Medicaid-insured Missourians while the Affiliate organizations do not receive allocations to serve uninsured or underinsured; rather, they are limited to those individuals with Medicaid. The match dollars for the Medicaid is provided via the State of Missouri for all provider organizations. Provider organizations are encouraged to pursue grant funding and to participate in Department driven funding opportunities. Provider organizations are required to staff programs with qualified staff for each service type. Provider organizations are required to ensure staff receive the necessary trainings to provide the service they are delivering. Trainings are available within organizations and via the Missouri Coalition of Behavioral Health Centers for provider organizations that are members of the Coalition. The State of Missouri requires Administrative Agents to meet and deliver crisis intervention services to all citizens of Missouri by providing telephone hotline and mobile crisis services. Some organizations staff hospital emergency rooms with trained mental health professionals to assist in meeting mental health crisis needs of those presenting at hospital emergency rooms. The State of Missouri is working cooperatively with law enforcement to ensure law enforcement are trained in handling mental health emergency and crisis situations. Additionally, the State of Missouri has worked with technical colleges to develop an associate’s degree for mental health workers. The State of Missouri also collaborated with the State Medicaid agency to expand the pool of medication service providers due to the shortage of psychiatrists in Missouri. The State of Missouri plans to continue to utilize funding to serve as many individuals as possible that are in need of mental health services and that these individuals be served by a sufficient number of adequately trained staff.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots ( ) Yes (●) No

c) Expanded community network for supportive services and healthcare ( ) Yes (●) No

d) Inclusion of recovery support services ( ) Yes (●) No

e) Health navigators to assist clients with community linkages ( ) Yes (●) No

f) Expanded capability for family services, relationship restoration, and custody issues? ( ) Yes (●) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Department contractually requires providers to admit pregnant women, arrange immediate admission with a different provider, and/or contact the Division of Behavioral Health to gain assistance in admitting the woman to an appropriate program.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	( ) Yes (•) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	( ) Yes (•) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Department contractually requires providers to admit person who inject drugs, arrange immediate admission with another provider, provide interim services and/or contact the Division of Behavioral Health (DBH) to gain assistance in admitting the individual to the appropriate program.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Department continues to contractually require programs to develop/maintain working relationships with a healthcare provider, local health department or other professional entity for the providence of tuberculosis testing and provide for post-test counseling when tests are positive as well as provide education to the participants, their families, and their significant others regarding risks of tuberculosis. Data reports are utilized to collect information pertaining to the number of individuals with tuberculosis and the number of individuals that received post-test counseling.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ( ) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	( ) Yes ( ) No
b)	Establishment or expansion of tele-health and social media support services	( ) Yes ( ) No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	( ) Yes ( ) No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)?	(●) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	( ) Yes (●) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (●) No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ( ) Yes (●) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

All providers are nationally accredited except two providers. Those accredited are not required to participate in a peer review per SAMHSA although when an agency is experiencing challenges, regardless of accreditation status, a peer review may occur as a means to provide technical assistance to the provider. Two peer reviews are anticipated for FY 2022-2023. DMH is moving toward the requirement of national certification for Comprehensive Substance Treatment and Rehabilitation (CSTAR) program providers.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

Council on Accreditation

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ◉ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) Mental Health TTC? ○ Yes ◉ No

c) Addiction TTC? ○ Yes ◉ No

d) State Targeted Response TTC? ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

General Program Procedures: https://www.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c10-5.pdf
Core Rules for Psychiatric and SUD Treatment programs: https://www.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c10-7.pdf
Substance Use Disorder Treatment Programs: https://www.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c10-7.pdf
Mental Health Programs: https://www.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c10-7.pdf

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

Department of Mental Health (DMH) and Missouri Trauma Roundtable developed, "Missouri Model: A Developmental Framework for Trauma Informed Approaches" in 2014, which provides guidance for organizations in their journey toward becoming trauma informed. Highlighting four stages - Trauma Aware, Trauma Sensitive, Trauma Responsive and Trauma Informed - it provides definitions, tasks, indicators and resources at each stage along with the continuum. Other states and countries around the world have used this model in various settings to aid organizations in creating trauma-informed care environments.

Missouri Children's Trauma Network (MOCTN), Department of Mental Health, Missouri Behavioral Health Council and Missouri

Academy of Child Trauma Studies (MoACTS) completed a two-year Trauma-Focused Cognitive Behavioral Therapy Learning Collaborative in 2020. The learning collaborative involved integrated teams of community mental health centers, Child Advocacy Centers, school-based mental health clinicians, Juvenile Offices, Children's Division Offices that are being trained to provide Trauma- Focused Cognitive Behavioral Therapy to youth and families, and educate communities about trauma and increase referrals for this evidence-based treatment. Across the state, eight to ten teams are participating in this learning collaborative and approximately 300 children received TF-CBT services
Missouri Children's Trauma Network successfully held their 5th Annual Conference virtually and had over 400 of attendees and had professional groups in attendance including mental health and substance use professionals, social workers, juvenile officers, school personnel, child advocacy centers and directors and supervisors.
MOCTN will focus on delivering training for the following EBPs for the upcoming fiscal year: Integrated Treatment for Complex Trauma (ITCT), Child Family Traumatic Stress Intervention (CFTSI), Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS), Child Parent Psychotherapy (CPP) and Clinical Supervision Learning Collaborative.

CCBHO/CMHC providers participated in Trauma Informed Organizational Self-Assessment and consultation, and ongoing trauma informed learning collaborative. In 2021-2022, Women's & Children's Comprehensive Substance Treatment and Rehabilitation (CSTAR) providers will participate in the same Trauma Informed Organizational Self-Assessment and consultation and participate in a 6 month-long trauma informed learning collaborative.

MHBG will provide Eye Movement Desensitization and Reprocessing (EMDR), Funds will also be used to provide H.E.A.T. Training, is a holistic, afro centric, strength based, trauma informed model that emphasizes a positive and engaging approach to treatment. H.E.A.T. is a promising practice, manualized intervention created to address the specific needs of Black/African American males ages 18-29 with involvement in the criminal justice system. The holistic approach of H.E.A.T. focuses on treating the complete person by addressing spiritual, mental, emotional, physical, environmental, and experiential factors that influence one's sense of self, behaviors, and choices. The curriculum seeks to validate life experiences and help the client address and resolve emotional and psychological issues that have shaped his self-image, behavior, and lifestyle choices. It is the only culturally responsive intervention of its kind in the country. Similarly, H.E.R. is a promising practice, therapeutic intervention created to address the specific needs of Black/African American women who have experienced victimization, have mild to moderate substance use disorders and who have current or past involvement with the criminal justice system; with an emphasis on Black/African American women. H.E.R. utilizes a strength based, holistic model to treatment that is both culturally relevant and responsive with an emphasis on providing a positive and engaging approach to treatment. Training is designed for professional groups including: substance use treatment providers, case managers, probation/parole officers, program directors/supervisors, mental health professionals, and recovery coaches.

Under the State Option to Provide Health Homes for Enrollees with Chronic Conditions, Missouri approved Complex Trauma as a condition that could qualify children and young adults, which would support early identification of and treatment for mental health, substance use and physical health conditions in an effort to decrease the likelihood of the development of chronic conditions and support resiliency and recovery.

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Please indicate areas of technical assistance needed related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

In 2017, Missouri leaders requested and received support for the U.S. Department of Justice, Bureau of Justice Assistance (BJA) to employ a Justice Reinvestment Initiative (JRI) approach to study the state's criminal justice system with technical assistance from the Council of State Governments (CSG). Missouri passed JRI legislation in 2018 and a JRI Executive Oversight Council (EOC) was established to set policy and oversee the project. The Director of DMH is co-chair of the JRI EOC. Three key findings emerged from a comprehensive analysis of data collection from state agencies: 1) there was an increase of violent crime, 2) there was a high recidivism rate among individuals on probation or parole, and 3) there was insufficient behavioral health treatment for individuals under supervision. DMH has representation on five JRI workgroups to address criminal justice reform in Missouri which include data monitoring, victims, crisis response, workforce development, evidence-based practices in DOC and behavioral health.

In 2018, the Department of Corrections (DOC) was appropriated funds and collaborated with DMH to implement a comprehensive, community-based program for individuals under the supervision of DOC who have substance use and/or co-occurring disorders and mild to moderate mental illness, and are considered high risk for reoffending. The JRI Treatment Pilot expanded and progressed beyond the pilot stage, prompting a name change in 2020 for the name to better reflect the program's objective of

Improving Community Treatment Success (ICTS) for justice-involved clients. ICTS adds care coordination, certified peer specialists, housing, transportation, employment assistance and wrap-around services which provide a holistic treatment model. An ICTS oversight team consisting of staff from DOC, DMH and local providers meets bimonthly to review outcomes and address unresolved issues.

In January 2021, a JRI Crisis Response Work Group was established. A member of DBH is co-chair of the work group. The charge of the work group is to 'support diversion from traditional criminal justice case processing for nonviolent offenders with behavioral health conditions (mental health disorders, substance use disorders, or both) that are significant factors in bringing them into contact with the justice system'. Membership is comprised of law enforcement, behavioral health treatment agencies, the courts, and other key stakeholders including the Governor's Office, DMH, Department of Public Safety, Department of Corrections, Department of Social Services, and Department of Elementary and Secondary Education, Missouri School Board Association, Missouri Coalition of Recovery Support Providers, Missouri Association of Counties, Missouri Municipal League, and the Veterans Administration.

In addition to JRI, DMH participates and/or facilitates several other inter-agency coordinating committees. More specifically, DMH facilitates monthly oversight meetings with DOC. The oversight team reviews a variety of data to determine outcomes and treatment needs that will promote public safety and diversion from re-incarceration. Further, the oversight team has developed numerous programs (Early Intervention, Integrated Handoff, High Risk Offender, Community Mental Health Treatment and Offenders with Serious Mental Illness) to expedite linkage of behavioral health services to individuals reentering communities. DOC and DMH have collaborated on two projects providing Medication Assisted Treatment (MAT), specifically Vivitrol, to individuals prior to their release from incarceration. DMH attends regular meetings with DOC regional administrators and participates in regional oversight meetings with DOC field staff and local behavioral health providers.

DMH is a voting member of the Treatment Courts Coordinating Commission which, by statute, is comprised of four judicial appointments and four executive branch appointments from the Departments of Social Services (DSS), Corrections (DOC), Public Safety (DPS) and Mental Health (DMH). The commission ensures resources are available to assist treatment court participants. The commission also oversees operations of the 147 treatment court programs. DMH and staff from the Office of the State Courts Administrator meet quarterly to collaborate and strengthen behavioral health services provided to the treatment court programs.

Missouri allocated additional state funding in 2021 to expand the successful Community Behavioral Health Liaison (CBHL) program. Fifty new CBHLS will be added to the existing 31 positions who assist law enforcement and the Courts in diverting individuals from emergency rooms, jails and prison. In 2020, over 15,000 referrals were made to CBHLs. Crisis Intervention Team (CIT) councils have been established throughout the state and CIT training is available, including an annual CIT conference. DMH staff attend quarterly CBHL and CIT meetings.

Missouri also allocated funds in 2021 to expand Crisis Stabilization Units (CSUs), providing at least one in each Missouri State Highway Patrol troop. CSUs provide intervention and assistance for law enforcement, CBHLs, and hospitals to connect someone in a behavioral health crisis, possibly preventing the individual from entering the criminal justice system and diverting them to community-based treatment most appropriate for their level of need.

Missouri has a robust Crisis Intervention Team (CIT) state council which includes local CIT councils, CBHLs, state agencies and associations, and those with lived experience. MO CIT works to address any structural barriers at the state level and advocates for policy and legislative changes to support health and wellness. MO CIT also provides direction and support on the CIT curriculum, training expansion, and implementation of the program.

DMH provides ongoing training on adolescent brain development, with focus on the impact of trauma for the Missouri Juvenile Justice Association Fundamental Skills curriculum offered statewide. DMH, DSS and the Juvenile Courts established a collaborative protocol for the three child service agencies to be able to divert youth from entering or remaining in state custody solely to access mental health services. MJJA sponsored a DMH staff to receive certification from the National Center for Youth Opportunity and Justice to deliver NCYOJ training for behavioral health to all MJJA detention personnel.

The Department of Mental Health (DMH) collaborates with Children's Division and Division of Youth Services in the Division of Social Services (DSS), the Office of State Courts Administrator (OSCA) and Georgetown University Center for Juvenile Justice Reform to implement a Crossover Youth Practice Model for juvenile justice reform in Missouri. DMH is a stakeholder in the Missouri Crossover Youth Policy Team and in 2021 worked with community partners to develop a Crossover Youth training and "toolkit." The toolkit supports jurisdictions in identifying crossover youth and improving practices for youth who are at risk of crossing over between child welfare and juvenile justice, or who are already known to both systems.

The Missouri Department of Mental Health (DMH) plans to use Mental Health Block Grant funds for adults who have serious mental illness or youth with serious emotional disturbance who are involved in the criminal justice system including those currently in jails. Missouri DMH plans to utilize these funds to provide mobile crisis services needed to assess and stabilize justice involved individuals in jail settings and to provide evaluation and treatment services via contracted community behavioral health providers. These services would be in addition to community services already available to individuals who are involved in the criminal justice system but not in jail.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Contracted Providers with the Department of Mental Health (DMH), Division of Behavioral Health (DBH) are required to make available, either through direct prescribing or via referral arrangements, all Food and Drug Administration (FDA) approved medications for the treatment of Alcohol Use Disorder (AUD) and Opioid Use Disorders (OUD). DBH contracted providers are able to provide medication services via telehealth, which allows for increased access to MAT in all areas of the state, with particular utility in Missouri's rural areas. By utilizing federal opioid crisis grant dollars Missouri's State Targeted Response to the Opioid Crisis (STR) and State Opioid Response (SOR) team developed and disseminated the Medication First treatment approach in

accordance with Medication First core principles, including providing pharmacotherapy as quickly as possible without tapering or time limits, continually offering but not requiring psychosocial service participation, and not discontinuing MAT unless it is worsening the individual's condition. This approach has been adopted by health care providers throughout the state and has gained national attention for succinct framing of evidence-based OUD treatment practices. Missouri continues to collaborate on innovative ways to increase access to quality OUD treatment for specialty populations, including providing training and technical assistance on OUD care for pregnant and postpartum women and; providing peer-based linkage to care in the emergency room through the Engaging Patients in Care Coordination (EPICC) program. To increase the number of prescribers of buprenorphine containing medications in Missouri, in collaboration with the Missouri Behavioral Health Council members and utilizing State Opioid Response grant funds, Missouri is connecting providers to and promoting free buprenorphine Data 2000 Waiver trainings across the state.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☑ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Missouri began the Emergency Room Enhancement (ERE) program in Fiscal Year 2013. The primary goals of ERE are to prevent repeated visits to emergency departments and acute hospitalizations and to decrease rates of homelessness, unemployment, arrests/law enforcement involvement. ERE programs are operating in thirteen regions across the state and covers 80 of the 114 Missouri counties. Each of the participating regions have partnered with local hospitals, community mental health centers, law enforcement agencies, substance use treatment providers and social service providers to coordinate care for the whole person by addressing behavioral, physical and basic needs.

The Youth Emergency Room Enhancement (YERE) program expands the scope of the ERE to transition youth from hospital or vulnerable settings to community care. Youth ERE clients have significant behavioral health needs, are age 6-17 (over 18, if still in high school), and not engaged in community behavioral health care. Those engaged in Youth ERE will typically be experiencing escalating behavior(s) that, without immediate intervention, may require a higher intensity and duration of services. Youth ERE seeks to increase timely connection to behavioral health and family support services, address social determinants of health needs (e.g. housing), and diminish barriers to youth and family engagement in services. The Youth ERE program operates in Missouri's Eastern Region, with services coordinated through five DMH providers.

DMH supports an Access Crisis Intervention (ACI) Mobile Crisis Pilot in which CMHC/CCBHO providers partner with DSS/Children's Division. The pilot allows DSS workers access to the Mobile Crisis Team and Family Support Providers for children placed in relative kinship placement and offers the children and families crisis intervention and counseling, mental health support and referrals for assessments and service enrollment.

In Fiscal Year 2022, the Missouri General Assembly approved funding for regional Crisis Stabilization Centers that help transition law enforcement from being the primary behavioral health response unit, to divert individuals in crisis away from jails or hospitals into behavioral health treatment services.

Missouri currently has 31 Community Behavioral Health Liaisons (CBHLs) who assist law enforcement and the courts in connecting individuals in crisis to behavioral health treatment services. Funding was also approved in Fiscal Year 2022 by the Missouri General Assembly to add 50 additional CBHLs to expand this successful program.

In Fiscal Year 2021, Missouri was awarded the 9-8-8 Planning grant. Soon, 988 will become the nationwide, 3-digit phone number for individuals experiencing a mental health crisis. Missouri has established a 988 Task Force made up of key stakeholders who will help guide the development of Missouri's 988 plan. There are currently seven active and onboarding centers in Missouri. These centers will be responsible for handling all 988 contacts in the state. The Task Force is frequently convening to discuss key considerations and prepare before implementation occurs. The 988 phone number will be a critical component in Missouri's crisis system.

Please indicate areas of technical assistance needed related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Clubhouses
Drop-in centers
Peer specialist
Peer wellness coaching
Family navigators/parent support partners/providers
Peer-delivered motivational interviewing
Self-directed care
Supportive housing models
Evidenced-based supported employment
Wellness Recovery Action Planning (WRAP)
Shared decision making
Person-centered planning
Self-care and wellness approaches
Room and board when receiving treatment

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery community centers
Peer recovery coaching
Peer wellness coaching
Family navigators/parent support partners/providers
Peer-delivered motivational interviewing
Telephone recovery checkups
Self-directed care
Supportive housing models
Evidenced-based supported employment
Wellness Recovery Action Planning (WRAP)
Person-centered planning
Self-care and wellness approaches
Room and board when receiving treatment

5. Does the state have any activities that it would like to highlight?

The Department of Mental Health remains committed to the development and sustainability of Recovery Support Services and Consumer Operated Service Programs.

Peer Support: Peer support services are available to individuals in behavioral health treatment. These services are face-to-face services or group services with a rehabilitation and recovery focus. Peer Specialists can share lived experiences of recovery, share and support use of recovery tools, and model successful recovery behaviors. Peer support services are Medicaid-reimbursable for mental health treatment. Missouri currently has over 1000 Certified Peer Specialists.

Family Support: Family support is a peer support service provided to parents and caregivers of children, youth, and young adults (18-25). Trained Family Support Specialists with lived experience provide individualized, one-on-one supports and services to the parents or caregivers. This may include providing information and resources to help the family better understand what is happening with their child. They also provide support to help the parents or caregivers develop problem-solving strategies and assistance in navigating the service system.

Drop-In Centers: DMH's Consumer-Operated Services Programs (COSPS) are peer-run service programs that are administratively controlled and operated by mental health consumers and emphasize self-help as their operational approach. DMH funds four Drop-In Centers that provide a safe place where consumers can go to find recovery programs and services provided by their peers.

Recovery Support Services: Recovery support programs offer services such as care coordination, recovery coaching, spiritual counseling, group support, recovery housing and transportation, before, during, after, and in coordination with other substance use disorder service providers. These services are offered in a multitude of settings including community, faith-based and peer recovery organizations. Recovery support programs are person-centered and self-directed allowing individual's choice of provider.

Recovery Community Centers: DMH received a SAMSHA State Opioid Response (SOR) grant for the purpose of expanding access to integrated prevention, treatment, and recovery support services for individuals with opioid use disorder throughout the state, including development of local Recovery Community Centers (RCC). Four RCCs provide a peer-based supportive community that builds hope and supports healthy behaviors for individuals with Opioid Use Disorders (OUDs) and Stimulant Use Disorders searching for recovery or maintaining recovery. Additional RCCs are being competitively bid with the Block Grant Supplemental funding.

Employment: DMH works to integrate clinical and vocational supported employment services through statewide partnerships with the Office of Adult Learning & Rehabilitation Services (Vocational Rehabilitation – VR) and provider agencies. The goal is to help individuals who are interested in employment participate in the competitive labor market in a job of their preference with the appropriate level of professional help needed to be successful. DMH has 32 community treatment providers designated as VR funded Community Rehabilitation Programs to provide supported employment services. Technical assistance, training, and fidelity reviews are conducted to ensure fidelity to the model. DMH supports the usage of Disability Benefits 101, which is a Missouri specific online tool designed to provide information on health coverage, benefits, and employment. The tool also provides information for veterans and youth interested in higher education.

Wellness: DBH has provided and will continue to provide training on WRAP and Wellness Coaching on the Eight Dimensions of Wellness. DBH continues to provide the wellness training based on Peggy Swarbrick's Collaborative Support Programs of New Jersey (CSP-NJ) and the University of Medicine and Dentistry of New Jersey, School of Health Related Professions, Department of Psychiatric Rehabilitation and Counseling Professions train-the-trainers model. DBH provides ongoing WRAP trainings both the two-day and five-day trainings.

Housing Supports: Housing is a critical component for recovery and wellness. The DMH Housing Unit coordinates both state and federal funds to provide direct rental assistance to individuals and families with mental illness, substance use disorders, developmental disabilities, and HIV/AIDS who are homeless or experiencing housing crisis. The DMH believes that housing is a key to helping Missourians with disabilities and their families attain self-determination and independent living.
A full array of housing options are available from residential care facilities to independent apartments. Recovery housing provides a safe, healthy environment that support residents in their recovery from substance use disorders. DMH contracts with the Missouri Coalition of Recovery Support Providers to accredit Recovery Housing using the National Alliance for Recovery Residences quality standards. Currently 151 Recovery Houses with over 1360 beds are accredited.

Please indicate areas of technical assistance needed related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	( ) Yes (•) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

The Governor's Council on Disabilities (GCD) is committed to advancing Missouri's compliance with the Supreme Court decision in Olmstead vs. L.C. The Council provides staff and resources to support this vital effort. The mission of the Council is to provide leadership and support so people with disabilities achieve inclusion and independence. The GCD Resource Directory is available at: https://disability.mo.gov/resource_search/. The Division of Behavioral Health (DBH) keeps informed and current with the Governor's Council's actions. DBH has numerous program, services and evidence-based practices that promote compliance with the Olmstead decision. The Missouri DBH has encouraged the Community Mental Health Center provider system to reach beyond psychiatric diagnoses by developing Disease Management programs, providing outreach to people with serious health/mental health/substance use disorders who are high utilizers of Medicaid, and coordinating services with the person's primary care physician, conducting metabolic screenings, and providing education about health and safety. The DBH has Individualized Placement and Support (IPS) employment services sites, and works with the State Department of Elementary and Secondary Education (DESE) to provide vocational rehabilitation services to DBH consumers. DBH works with community providers to build access and/or fund appropriate housing for each individual. Housing options across the state range from Housing First programs to Residential Care Facilities with specialized Psychiatric Independent Supported Living (PISL) homes, clustered apartments, safe havens, and Intensive Residential Treatment Settings (IRTS). Assertive Community Treatment (ACT) teams and Intensive Community Psychiatric Rehabilitation are provided for people living independently in the community who need additional supports. Supported Community Living dollars help people live in the setting of their choice. Other housing funding options include Shelter Plus Care, Rent Assistance Program, and Section 8 Housing.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Through local system of care teams across the state, Department of Mental Health (DMH) works with Missouri's child-serving systems, families and youth to collaborate and coordinate behavioral health services. The function of system of care teams include: addressing system and community barriers to appropriate services; providing expert recommendations and data to public policy makers as it relates to the needs of youth and families; advocating for prevention, early intervention and treatment recovery; ensuring clinically appropriate integrated services are available and provided; and/or increasing access and family engagement in all services to youth and families. Local System of Care teams are made up of family members, family run organizations, DMH, Department of Health and Senior Services (DHSS), Department of Social Services (DSS)/Children's Division (CD), Department of Elementary and Secondary Education (DESE), Juvenile Justice and other local child serving agencies.

The Department of Mental Health has established a new position, the Children's Director, seated within the Director's Office. The Children's Director provides oversight of an inclusive DMH Children's Team which is structured to coordinate behavioral health services across the Behavioral Health and Developmental Disabilities Divisions in DMH to better support all Missouri youth. The Children's Team, under the supervision of the Children's Director, draws experts within DMH together to create and maintain behavioral health policies and clinical practices that support and promote positive outcomes for youth and families in MO, no matter what their point of entry into DMH services.

7. Does the state have any activities related to this section that you would like to highlight?

Family Support Providers allow caregivers to receive assistance while their children receive treatment of behavioral or substance use disorders. These parent peers assist parents and caregivers in working through problems encountered during the time that the child receives a diagnosis which is when support is needed the most. Problem solving tools, self-esteem building, and working through fears are just a few of the areas in which family support providers may help parents/caregivers.

Youth Peer Support Specialists support, encourage, and model positive self-advocacy, recovery and resiliency for youth ages 13-25. The Division of Behavioral Health (DBH) requires all Youth Peer Support Specialists providing services to youth under the age of 18 to be certified in youth peer support. A nationally recognized training curriculum with content specifically geared to the youth and young adult population is utilized. Youth Peer Support Specialists understand youth culture through traditional education and through the knowledge they gain from their lived experience.

MO TAYLER: Missouri Transition Aged Youth Local Engagement & Resources aims to improve access to treatment, increase emotional and behavioral health functioning, maximize potential to assume adult roles and responsibilities, and lead full, productive lives for youth and young adults ages 16-25. Providers promote culturally competent, developmentally appropriate services and intervention approaches to youth and young adults with serious mental disorders in three Missouri communities. Outreach and engagement occurs for youth and young adults with first episode psychosis and outreach staff shadow staff in the DMH-funded Emergency Room Enhancement (ERE) and Youth Emergency Room Enhancement (YERE) initiatives. A social media presence has been established through #HelpIsHereSTL, Instagram, Facebook.

To enhance collaborative, community-based services provided to youth, DMH will work with CMHC/CCBHO providers to establish Youth Behavioral Health Liaisons (YBHL). A YBHL is a mental health professional who forms local community partnerships with various youth-serving organizations to address specific behavioral health needs of vulnerable children and youth. The YBHL will function as a service connector for youth with co-occurring mental illness, substance use and/or developmental disability to link youth to services available through community partners. A primary goal in establishing YBHLs is to form better community partnerships between Community Mental Health Centers and other behavioral health treatment providers, Juvenile Office and Family Courts, Children's Division, and hospitals to help improve outcomes for youth with behavioral health issues. YBHLs will work to divert youth from inpatient hospitalization and out-of-home placements such as residential treatment centers, juvenile detention, and jail, while supporting youth in natural family and/or community-based setting. Through their interactions with the YBHLs, youth and families with behavioral health issues and developmental disabilities who have frequent interaction with Children's Division, Juvenile and Family Courts, law enforcement and inpatient hospitals will have improved access to behavioral health treatment.

Please indicate areas of technical assistance needed related to this section.

N/A

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The "Show Me Zero Youth Suicide" initiative aims to reduce youth suicide through in integrated systems-level approach, which includes establishing a continuity of care model for youth at risk of suicide and promoting the adoption of suicide prevention as a core priority of youth-serving institutions, such as hospitals and schools. Through collaboration with these organizations, this initiative is effectively identifying youth ages 10-24 who are at risk for suicide and providing them immediate linkage to intensive services and follow-up care.

Services are being focused on a five-county region in western Missouri, centered on Jackson County, which includes Kansas City, as well as the surrounding counties with more rural areas. The overall aim of the "Show Me Zero Youth Suicide" initiative is to reduce suicides and suicide attempts by accomplishing three major goals:
1) Improve the system of care of suicidal youth who use hospital emergency departments,
2) Improve the capacity of school system to identify, respond, and refer youth at risk of suicide,
3) Strengthen overall prevention efforts for at-risk youth populations in other settings.

Under the Zero Suicide Grant, Missouri is integrating the Zero Suicide model into multiple health systems by:
1) Improving care coordination in emergency departments and hospitals,
2) Strengthening the state's crisis hotlines,
3) Expanding Zero Suicide in the statewide behavioral healthcare system and its associated referral systems, and
4) Developing a statewide collaborative to guide policy and develop protocol for zero suicide prevention planning in Missouri.
This project is serving adults age 25 and older who have behavioral health disorders, adults and their families experiencing crisis and Missouri veterans at risk but not currently served by the Veterans Health Administration.

An intensive care coordination model is being piloted in Missouri's two largest urban cities, Kansas City and St. Louis, through partnerships with local behavioral health providers and 18 hospitals/emergency departments.

Missouri's Suicide Response to COVID-19 Project
In July 2021, MO Department of Mental Health (SMH) was awarded the Missouri Suicide Response to COVID-19 Project (MSRCP). Under this SAMHSA grant, DMH is collaborating with two mental health providers: Compass Health and Behavioral Health Response (BHR) to serve adults 25 and older at-risk for suicide, including those at-risk for domestic violence. MSRCP is working to mitigate these results and reduce the overall number of suicides through the integration of suicide prevention in healthcare systems in counties devastated by COVID-19. This project is utilizing effective practices for suicide outreach, assessment, intervention, and treatment to provide rapid follow-up for adults accessing emergency departments, inpatient hospitals, and other community settings due to a suicidal crisis and/or domestic violence. MSRCP is providing rapid response services across twelve high-risk counties due to suicide rates, COVID-19 cases and domestic violence. Over the 16-month project period, MSRCP plans to serve over 2,000 at-risk adults, with over 500 of those being victims of domestic violence survivors. MSRCP will align community-based efforts through working in partnership with the Missouri Suicide Prevention Network (MSPN) to establish a statewide communications approach for suicide awareness, a rapid response plan and obtaining real-time data to guide continuous efforts. Statewide training is being provided on evidence-based practices and recommendations including 1) Best practices in care transitions for individuals with suicide risk; Inpatient care to outpatient care and the Recommended Standard Care for People with Suicide Risk; Making Health Care Suicide Safe, 2) Collaborative Assessment and Management of Suicidality (CAMS), 3) Counseling on Access to Lethal Means (CALM), 4) Trauma-informed care and domestic violence best practices, and 5) Stanley Brown safety planning training. Through the multi-pronged approach of utilizing 1) intensive, emergency suicide response for adults and domestic violence victims, 2) coordination with Missouri Suicide Prevention Network to address statewide

community recovery supports, and 3) utilization of evidence-based trainings; MSRCP will significantly reduce the suicide rate and number of suicides in Missouri. MSRCP is directly in line with SAMHSA's initiative to reduce the number of suicides nationally and mitigate the behavioral health impact of COVID-19.

Signs of Suicide (SOS) Training
Department of Mental Health (DMH) contracted Prevention Resource Center (PRC) staff have been trained as SOS Trainers. The PRCs provide this training to school staff across the state. This curriculum helps students identify the warning signs and risk factors of depression and suicidal ideation in themselves and others.

Zero Suicide Initiative
Under the Zero Suicide Grant, DMH hosted its fourth Zero Suicide Academy with fourteen organizations in attendance. DMH continues to hold bi-monthly Zero Suicide Learning collaborates for all attendees of the Zero Suicide Academies.

Suicide Prevention Campaign
DMH continues to run statewide suicide prevention and awareness campaigns targeting the states most vulnerable populations. The Crisis Text Line Campaign encourages youth and young adults to text if they are experiencing stress, a crisis or need someone to talk to. The adult suicide campaign provides awareness information and direct adults in crisis to reach out.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

DMH has implemented a suicide campaign targeting youth ages 10-24. The aim of this campaign is to increase help seeking among this population through advertising the Crisis Text line.

DMH is providing 14 free QPR virtual trainings for Substance Use Disorder professionals. The QPR Institute approved training is a modification of QPR that includes specific information relevant to those working with SUD including information to illustrate how SUD can increase the risk of suicide, the different risks associated with suicide based on the different stages of change, and ways QPR is utilized in SUD treatment facilities.

Missouri Suicide Prevention Network
In 2018, MO Department of Mental Health collaborated with the Coalition for Community Behavioral Healthcare to create an independent, non-partisan, voluntary group of individuals and organizations (public and private) to lead and coordinate statewide suicide prevention efforts.

Suicide Prevention in Healthcare Extension for Community Health Outcomes (ECHO)
Suicide Prevention in Health Care ECHO educates and empowers providers to competently and confidently treat individuals at risk for suicide. A multidisciplinary team of mental health experts share information about best practices, plans and procedures. Primary care and emergency medicine providers, school officials, law enforcement personnel and other professionals who interact with the mental health community are encouraged to participate.

Please indicate areas of technical assistance needed related to this section.

N/A

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20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

The Department of Mental Health (DMH) is partnering with the Department of Elementary and Secondary Education (DESE), Missouri Head Start, Department of Health and Senior Services (DHSS) and Department of Social Services (DSS) to support the new Office of Childhood in Missouri. The office will ensure that children and families in Missouri have better access to more consistent, quality programs and services that support early childhood care and education, early learning, early intervention, and positive social and emotional development.

DMH has also enhanced partnerships with other state agencies, including Department of Natural Resources in terms of suicide prevention projects and additionally DMH providing an externship where a DMH staff spent a specified amount of time with the department and their visiting their parks to learn and give guidance on suicide and trauma in the state parks.
MU Extension has recently collaborated with DMH to work toward Recovery Friendly Workplaces. Additionally, DMH has been working closely with Missouri Primary Care Associate (MPCA) this past year on integration efforts involving our community treatment providers and the Federally Qualified Health Centers.

Please indicate areas of technical assistance needed related to this section.

N/A

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21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

As of 2018, Missouri's two separate planning councils merged into one planning council with two subcommittees. The State Advisory Council on Alcohol and Drug Abuse (SAC-ADA) and State Advisory Council on Comprehensive Psychiatric Services (SAC-CPS) merged to become the Division of Behavioral Health State Advisory Council (SAC). The SAC consists of up to 32 members who have a professional, research, or personal interest in prevention, recovery, evaluation, treatment rehabilitation, and system of care for children/youth with serious emotional disturbance and persons affected by behavioral health disorders and their families. The SAC shall include service providers, consumers (recipients of services or family members of recipients), and other interested citizens. The SAC shall include representatives from non-government organizations or groups and state agencies concerned with the planning, operation or use of behavioral health services; individuals with mental health and/or substance use disorders who are receiving or have received behavioral health services and who are familiar with the need for such services; and family members of adults with mental health and/or substance use disorders or families of children with emotional disturbance. At least one member shall represent veterans and military affairs. At least one-half of the members of the SAC shall be recipients of behavioral health services or family members of recipients. No more than one-half of the members of SAC shall be providers as defined as an entity/service delivery system, which uses, purchases and/or coordinates with mental health, substance use, or developmental disabilities services provided by contracts with the Department of Mental Health. Representatives of state agencies responsible for mental health, education, vocation rehabilitation, criminal justice, housing, social services and Medicaid are mandated. Membership terms are three years and a member may serve an additional three year term if nominated and approved by the SAC and the Division Director. The SAC shall recognize two standing committees, the Mental Health Disorders Committee and the Substance Use Disorders Committee. The purpose of these committees is to ensure adequate representation and focus on the issues unique to each committee. The co-chairpersons of these standing committees shall equally share the leadership of the full SAC. The mission of the SAC is to advise the Division of Behavioral Health in the development, funding, prevention, public understanding and coordination of specialized services to meet the needs of Missourians with mental health and substance use disorders. In order to accomplish this mission the SAC shall collaborate with the DBH to develop and review the state plans for delivering behavioral health services pursuant to Title 42, 300x-3 (Federal statute) and CSR 631.020.8.; advise DBH in the development of models of services and long range planning and budgeting priorities; identify statewide needs and recommend what specific methods, means, and procedures should be adopted to improve and upgrade the behavioral health service delivery system for citizens of this state; provide education and information about mental health and substance use; monitor, evaluate, and review the allocation and adequacy of behavioral health services within the state; and provide oversight for suicide prevention activities.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The SAC provides a diverse perspective on the prevention and treatment of substance use and mental health. SAC meetings include updates, presentations, and discussions from the Division of Behavioral Health (DBH) Director and/or his representative and section heads from prevention, treatment, and fiscal units. In addition, the SAC receives regular briefings and feedback from the Missouri National Alliance on Mental Illness, Missouri Protection & Advocacy, and Children's Services. The SAC also receives regular briefings from the Missouri Credentialing Board on matters pertaining to professional credentialing and workforce development.

Additionally, the SAC serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. SAC advocacy activities include promoting the Consumer/Family/Youth Conference as well as Peer Specialist training and certification. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. The SAC coordinates recommendations on behavioral health services, including recommendations for Missouri's FY 2020-2021 Behavioral Health Assessment and Plan and the State Suicide Prevention Plan. In addition to the regular briefings, the SAC has been audience to presentations from numerous experts in areas from cultural competency, to Missouri public administrators and guardianship, the Missouri Opioid State Targeted Response and State Opioid Response Projects, and the impact of COVID and attitudes.

The SAC currently has two project committees which address special issues identified by the SAC or the DBH as topics relevant to the SAC purpose, authority or to the Behavioral Health delivery system. The Children and Family Committee is focused on enhancing services for family members of children/youth. The Outcomes Committee is focused on current state-wide data for family therapy services.

The SAC informs and supports the annual peer summit event in Missouri. The Missouri Recovery Alliance hosted their first Peer Summit in May 2020. This is a new organization that is 100% peer run and guided by individuals with lived experience in recovery from substance use disorders. They are working to unite peers around the state, teaching them how to advocate and giving them cutting edge, evidence-based training so they can continue to give support to other peers in the behavioral health system. Over 300 people participated in this conference.

Real Voices Real Choices is the annual consumer conference to educate, inform, and empower individuals in treatment and/or recovery and their families. This conference developed from Missouri's Mental Health Transformation Grant, a SAMHSA-funded grant that ended in 2011. The 2021 conference will be held virtually in August.. The SAC encourages and fosters the advancement of this annual event.

The SAC endorses the Missouri's Mental Health Champions – an effort to recognize the accomplishments of individuals whose lives have been challenged by mental illness, substance use disorders, and/or developmental disabilities. The 2021Mental Health Champion awards ceremony and banquet is planned to be held on October 5th at the Capitol Plaza Hotel in Jefferson City.

Please indicate areas of technical assistance needed related to this section.

N/A

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Footnotes:

MICHAEL L. PARSON
GOVERNOR

MARK STRINGER
DIRECTOR

NORA K. BOCK
DIRECTOR
DIVISION OF
BEHAVIORAL HEALTH

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
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June 2, 2021

Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd, Room 7-1091
Rockville, MD 20850

Dear Grants Management Officer:

The State Advisory Council for the Missouri Department of Mental Health, Division of Behavioral Health (DBH), has reviewed the state's FY2022 – 2023 Behavioral Health Block Grant State Plan – which combines plans for both mental health and substance use disorders. The State Advisory Council is committed to working with the DBH to create a well-integrated system of care that implements evidence-based practices and incorporates a focus on recovery. The State Advisory Council had many months to develop, review, discuss, and make recommendations regarding the Behavioral Health Block Grant State Plan. The Council met June 2, 2021, and voted to approve Missouri's final State Plan, written under our guidance.

We will continue to work with the DBH monitoring the implementation of the State Plan. We appreciate our involvement in the Block Grant planning development. We would like to express appreciation to SAMHSA for making these funds available.

Sincerely,

Denise Mills, Chair
State Advisory Council

David Stoecker, Chair
State Advisory Council

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Kristi Booth	Persons in recovery from or providing treatment for or advocating for SUD services		901 N Missouri Street Cape Girardeau MO, 63701 PH: 573-837-8773	Kristilbooth@gmail.com
Korin (Kory) Boustead	Parents of children with SED/SUD		408 Deer Valley Court Jefferson City MO, 65109 PH: 573-462-0190	koryboustead@gmail.com
Cher Caudel	Providers	Public Administrator of Moniteau County	200 E Main St California MO, 65108 PH: 573-796-4704	moniteaucopa@gmail.com
Daniel Cayou	Providers	Missouri Protection & Advocacy	925 S Country Club Drive Jefferson City MO, 65109 PH: 573-893-3333	daniel.cayou@mo-pa.org
Tim Collier	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		20480 Henry Lane Dixon MO, 65459	mrcolliert@yahoo.com
Michael Eanes	Persons in recovery from or providing treatment for or advocating for SUD services		3201 Martha Drive Columbia MO, 65202	meanes@connectiontosuccess.org
Lawrence Freeman	Persons in recovery from or providing treatment for or advocating for SUD services		105 Layla Lane Popular Bluff MO, 63901 PH: 314-438-7768	lawfreeman1948@gmail.com
Stacey Gilkey	Parents of children with SED/SUD		1587 NE Rice Road Lees Summit MO, 64086 PH: 816-581-5872	sgilkey@rediscovermh.org
Derrick Green	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3618 W. Maplewood Street Springfield MO, 65807 PH: 417-425-8711	derrickjgreen@gmail.com
	Individuals in Recovery (to include		13655 Riverport	

Lindsey Hammond	adults with SMI who are receiving, or have received, mental health services)		Drive Maryland Heights MO, 63043 PH: 763-361-6476	lindsey_hammond@uhc.com
Christa Harmon	Persons in recovery from or providing treatment for or advocating for SUD services		PO Box 116 Sullivan MO, PH: 573-259-2814	mrsmooch73@gmail.com
Marcia Hawkins-Hourd	Providers	Child and Family Empowerment	7036 Camden Court St Louis MO, 63106 PH: 314-274-2524	mhourd.tcu@gmail.com
Emily Jung	Persons in recovery from or providing treatment for or advocating for SUD services		11 Lockhaven Court Lake Saint Louis MO, 63367	emily.jung@archwayinstitute.org
Kelli Kemna	State Employees	Missouri Dept of Mental Health/Housing	1706 E Elm St Jefferson City MO, 65102-0687 PH: 573-522-6519	Kelli.Kemna@dmh.mo.gov
Richard Kenney	Persons in recovery from or providing treatment for or advocating for SUD services		103 North Wildwood Carl Junction MO, 64834 PH: 417-438-5301	tkenney@mchsi.com
Shane Laswell	Persons in recovery from or providing treatment for or advocating for SUD services		8023 Oakfield Drive O'Fallon MO, 63368 PH: 636-561-5680	
Eric Martin	State Employees	Missouri Dept of Social Services/Medicaid	615 Howerton Jefferson City MO, 65109 PH: 573-522-8336	Eric.D.Martin@dmh.mo.gov
Missy McGaw	State Employees	Missouri DESE/Vocational Rehabilitation	7712 N. Myrtle Ave Kansas City MO, 64119	missy.mcgaw@vr.dese.mo.gov
Molly McGrath	State Employees	Missouri Department of Health and Senior Services	912 Wildwood Drive Jefferson City MO, 65109 PH: 573-526-4389	molly.mcgrath@dmh.mo.gov
Tara McKinney	Providers	Missouri Department of Health and Senior Services	930 Wildwood Drive Jefferson City MO, 65109	
Michael Melion	State Employees	Missouri Department of Corrections	2729 Plaza Drive Jefferson City MO, 65109 PH: 573-526-6523	michael.melion@doc.mo.gov
Denise Mills	Family Members of Individuals in Recovery (to include family members of adults with SMI)		624 E Wayne Street Republic MO, 65738 PH: 417-308-7455	dmills@compasshn.org
Addonya Nelson	Providers	Family Counseling Center	111 Alishia Ave Poplar Bluff MO, 63901 PH: 573-712-2904	addonyaevettemarie@gmail.com
Brandon Noel	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		10265 Baltimore Avenue Saint Anne MO,	B.noel@wustl.edu

Bobbi Jo Reed	Persons in recovery from or providing treatment for or advocating for SUD services		4505 St John Avenue Kansas City MO, 64123 PH: 913-706-2222	reedbobbijo@gmail.com
Angela Reynolds	Providers	St. Joseph Youth Alliance	5223 Mitchell Avenue St Joseph MO, 64507 PH: 816-232-0050	areynolds@youth-alliance.org
Corey Reynolds	Family Members of Individuals in Recovery (to include family members of adults with SMI)		2080 Three Rivers Blvd. Poplar Bluff MO, 63901	creynolds@trcc.edu
Barb Scheidegger	Parents of children with SED/SUD		2623 Idlewood Road Jefferson City MO, 65109 PH: 573-619-1322	mofam4fam@gmail.com
Gregory Smith	Persons in recovery from or providing treatment for or advocating for SUD services		810 Wildwood Drive Jefferson City MO, 65109	gregdsmith1269@aol.com
Amber Stockreef	State Employees	Missouri Department of Mental Health	1706 E. Elm Street Jefferson City MO, 65102-0687 PH: 573-526-0350	Amber.Stockreef@dmh.mo.gov
David Stoecker	Persons in recovery from or providing treatment for or advocating for SUD services		1925 E. Bennett Springfield MO, 65804 PH: 417-268-7489	david.stoecker@gmail.com
Amye Trefethen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2114 Millbrook Court Jefferson City MO, 65101	amye@namimissouri.org

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Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**32**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	10	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**20**	**62.50%**
State Employees	6	
Providers	6	
Vacancies	0	
Total State Employees & Providers	**12**	**37.50%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**10**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

At the February 2021 meeting, the State Advisory Council (SAC) was presented with a review of the behavioral health service delivery system and the annual performance measures that were reported on the FY 21 SABG Report and FY21 MHBG Report. Additionally, the SAC was presented with the planned updated priority indicators and performance measures. The SAC is presented with ongoing fiscal updates at each meeting in regard any changes to the Block Grants or State Budget. The council was given an opportunity to ask questions or make comments during the February 2021 meeting and subsequent meetings through the application deadline. The SAC members were provided with contact information to provide any additional comments outside of meeting times. No recommendations were received from SAC members to modify the application. The SAC provided a letter of support for the

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22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	(•) Yes ( ) No
b)	Posting of the plan on the web for public comment?	(•) Yes ( ) No
	If yes, provide URL: https://dmh.mo.gov/behavioral-health/block-grant	
c)	Other (e.g. public service announcements, print media)	( ) Yes ( ) No

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Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Missouri does not fund a Syringe Services Program with SABG funds.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Missouri does not fund a Syringe Services Program with SABG funds.